Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 2 () 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** rne m /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number 8. Date of Birth (Month, Pay, May 19 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. If Under Birthplace (State or Foreign **Funeral** Days 216-36-433 Usual Residence of Decedent Months 1)X M 2□F Director NIa Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
snt: If item 27 is marked other then "natural", or Items 23a or 28a-f show 10a. State 10b. County ir then "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 □ No by Funerai Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/2/6 6 na 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 MNo
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never 100 or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ liam sarnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Brother) Mo harle 21216 salto, Md. Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Green Mount Cremdory 126/2004 ⁴ 4 □Donation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility oseph L. Russ Funeral 222 W. North Ave. Bayto. Hame 23a. Parti. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 1 NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No ۴ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 PNatural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01/4 MD

State Registrar 30. Name and address of

31. Date filed (Month, Day,

person whi

Year)

DHMH 17 Rev 1/2001

(Type, Print)

mpleted cause of death (Item 23a)

32. Registrar's Signature

IN

To the Hospitei or Attanding

State

Registrar

Medical

29a. Certifier

29b. Signature and

5,

30. Name and address of person who completed HOGA 31. Date filed (Month, Day, Year) APR 2 2 2004

equse of death (Item 23a) (Type, Print) 82. Registrar's Signature

and manner stated.

111 Penn Street, Baltimore, Maryland 21201 Darks

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 19, 2004

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 12503 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 930Am **Physician** 4a Fecility Neme (If not institution, give street end number) OL /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner LONG-GREEN (TENESIS Eldercar ff Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 F Months Yrs. 217-24-5696 Va Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or itams 23a or 28a-f show Md N/A Balto 1 X Yes 2 ☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 11 W. 20th Street 21218 permit. Peges 1 and 2 should be filed within 72 hours efter death Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or itama 23 any Injury or other traumetic event, the Medical Examinal must Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Black ð 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12th grade College (1-4or 5+) Home N/A Domestic 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be James Roane Harriett Lewis ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richmond, Va 23227 Gerald Roane - Nephew 8302 Audlay Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4-22-04 Anne Arundel Co, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility ature of Funeral Service Licens March F/H West 4300 Wabash Avenue Balto, Md 21215 23a. Pet 1. Enter the disease, or complications that caused the death. It not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on- cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of Physician/Medical Examiner Pom or Attending Physician: The law requires that the death certificate be executed ettending physician and for use es the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Du to (or as a consequence of): indent Division of Vital Records, P.O. Box 68760, Dry vanc Due to (or as a consequence of) Part II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Š 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Menner of Death 28c. fnjury et Work? 1 Maturel 5 Pending investigation efter death. Diractor: Aft 1 🗌 Yes 2 🗌 No 2 Accident 28i. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined To the Hospital or Atte within 24 hours effer de:
To the Funeral Directo completely filled in by th 3 Suicide 28e. Plece of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m) 30. Name end eddress of person who completed cause of death (ftem 23a) (Type, Print) N. Enton It Sinte 304 4Af Hm1 mi) 21 SHOA(13

DHMH 16 Rev 6/95

Registrar

31. Dete filed (Month, Day, Year)

2004

ORIGINAL

32. Registrer's Signeture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #19a per informant 0830 4/28/04 tas

Amend Item # 18, per FH, 0830, 4/26/2001 of Death

Reg. No. 2 0 0 1 Reg. No. 2004 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 20, 2004 12:20 P™ April Barbara S. Berry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Keswick Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🛣 F Yrs. Dune 11, 66 216-34-1317 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturel; or Items 23a or 28a-1 show ury or other thaumatic event, Item Modical Examples must be notified at 1 ☐ Yes 2 🛛 No Director MD Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Pot Spring Road 21093 United States 2104 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Legal Assistant Law Firm 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Knight Lillian Edward Santora Lillian Zelenka ို Mindson (Treatmenship (Type, Print)
Linda Chessare/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fallow Field Road Fairfield, Conn 06430 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 04/2472004 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, MD. permit. Page Department of Importent: If eny injury or once. Dulaney Valley Mem. Grdns. 4 ☐ Dogation 5 ☐ Other (Specify) 21. Signature of Furleral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. S. D. Coster 1050 York Road, Towson, MD 21204 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ogvessi ul ars **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit death certificate be executed Due to (or as a consequence of): attending physician a P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown The law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 2 No 1 ☐ Yes 2 ☐ No certificate 1 Yes Physicien: To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ¥Yes 2 No 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 5 Pending 1 Natural 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 125205 April 21, 2004 Key, MD

DHMH 17 Rev 1/2001

State Registrar 6701 W. Charles St. Balto. Md 21204

30. Name and address of person will completed cause of death (Item 23a) (Type, Print)

GBMC

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Physician   Physic				For	State of Ma		d / De	partme	nt of He	alth and I	•		ne 200	1. 1050
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The control of the		and al-trai	хаг	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of)	:					0	
FEMALE:   230. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	8	be e siciari buri	alE											
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State	r	that		Part II. Other significant conditions of	ontributing to death to	out not res	ulting in th	ne underlying	g cause given	in Part I.	23e	Did tobacc	o use contribute to	the cause of death?
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25. Was case referred to medical examiner?  15. Was case referred to medical examiner?  16. Was case referred to medical examiner?  18. Cartifying Physician: 15. In patient 2   28t. Injury at work?  19. Sat. Date live of Sub cartifying Physician: 15. In patient 2   28t. Injury at work?  19. Sat. Date live of Sub cartifying Physician: 15. In patient 2   28t. Injury at work?  19. Sat. Injury at work?  19. Sat. Date live of Sub cartifying Physician: 15. In patient 2   28t. Injury at work?  19. Sat. Injury at work?  19. Sat. Date live of Sub cartifying Physician: 15. In patient 2   28t. Location (Street and Number or Rural Route Number, City or rown, State)  19. Sat. Date file of Outh Number, And Number or Rural Route Number.  19. Sat. Date file of Outh Number, And Number or Rural Route Number.  19. Sat. Date file of Outh Number, And Number or Rural	S S	w rec	lete								24a	Was an	24b. Were at	utopsy findings available
25. Was case referred to medical examiner?  15. Was case referred to medical examiner?  16. Was case referred to medical examiner?  18. Cartifying Physician: 15. In patient 2   28t. Injury at work?  19. Sat. Date live of Sub cartifying Physician: 15. In patient 2   28t. Injury at work?  19. Sat. Date live of Sub cartifying Physician: 15. In patient 2   28t. Injury at work?  19. Sat. Injury at work?  19. Sat. Date live of Sub cartifying Physician: 15. In patient 2   28t. Injury at work?  19. Sat. Injury at work?  19. Sat. Date live of Sub cartifying Physician: 15. In patient 2   28t. Location (Street and Number or Rural Route Number, City or rown, State)  19. Sat. Date file of Outh Number, And Number or Rural Route Number.  19. Sat. Date file of Outh Number, And Number or Rural Route Number.  19. Sat. Date file of Outh Number, And Number or Rural	E E	he la e has sge 2	Ĕ									performed	? death?	_
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29a. Certifier (Check only 2   Medicel Exeminer: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Narfe and address of person who completed cause of death (Item 23a) (Type, Print)  Sherell Mason, MD 22 S. Greene Street., Baltimore, Md 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature	>	sicle s cert lirect	8	examiner?	Hospital:	ont 2 🗆	ER/Outo	ationt 3	Other				6 □Othor (Soc	oifu)
29a. Certifier (Check only 2   Medicel Exeminer: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Narfe and address of person who completed cause of death (Item 23a) (Type, Print)  Sherell Mason, MD 22 S. Greene Street., Baltimore, Md 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature	5	Phy or this oral o	-		28a. Date of Inju	μV	28b. Tin	ne of	28c. Injury a	it				ony)
29a. Certifier (Check only 2   Medicel Exeminer: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Narfe and address of person who completed cause of death (Item 23a) (Type, Print)  Sherell Mason, MD 22 S. Greene Street., Baltimore, Md 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature		Affer fun	iệ.		1 10 10 1	y Year)					Sub	ject	Fell	
29a. Certifier (Check only 2   Medicel Exeminer: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Narfe and address of person who completed cause of death (Item 23a) (Type, Print)  Sherell Mason, MD 22 S. Greene Street., Baltimore, Md 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature	2	Atter r dea actor by the	fica	3 Suicide 6 Could not be	28e. Place of In	jury - At h	ome, farm	, street, fact	ory, office		28f. Loca	tion (Street	and Number or R	ural Route Number,
29a. Certifier (Check only 2   Medicel Exeminer: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Narfe and address of person who completed cause of death (Item 23a) (Type, Print)  Sherell Mason, MD 22 S. Greene Street., Baltimore, Md 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature	$\leq$	after after d in t	ert	4   Homicide	Market	t					Holl	ins S	St. Troo	
30. Narrie and address of person who completed cause of death (Item 23a) (Type, Print) Sherell Mason, MD 22 S. Greene Street., Baltimore, Md 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		spite		29a. Certifier 1X Certifying Ph	ysician: To the best	of my kno	wledge, d	death occurre	ed at the time,	, date and place	Balto and due	o the cause	(s) and manner as	s stated.
30. Narrie and address of person who completed cause of death (Item 23a) (Type, Print) Sherell Mason, MD 22 S. Greene Street., Baltimore, Md 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		ne Hc	dic	(Check only / 2 Medical Exer	niner: On the basis of	of examina	tion and/	or investigati	on, in my opin	nion, death occu	irred at the	time, date a	and place, and due	to the cause(s)
30. Narrie and address of person who completed cause of death (Item 23a) (Type, Print) Sherell Mason, MD 22 S. Greene Street., Baltimore, Md 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		To the within To the comp	M	1/10				1						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sherell Mason, MD 22 S. Greene Street., Baltimore, Md 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		-		> threat the	Esty Mil	10			P15824	4		Apr	T11 20,	2004
State State 31. Date filed (Month, Day, Year) 32. Registrar's Signatule State State 31. Date filed (Month, Day, Year)					completed cause of	leath (Iter	n 23a) (Ty	/pe, Print)					21221	
		5			MD 22 5	S. G	reer	ne St	reet.	, Balt	imor	e, Mo	1 21201	
				31. Date filed (Month, Day, Year)	32. Registr	rar's Signa	tule	Low	KN					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 12506 Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Year Month **Physician** 5:30 a M BROCKTON April 2004 TOROY 19 DAVID /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner N/A MILLENIUM OF FRANKLIN SQUARE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, ) Dec • 25 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex. 1 **⊠N** 2 ☐ F **Funeral** 1921 SOUTH CAROLINA 82 Yrs. Dec. Director 241-30-6099 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehrow any injury or other treumatic event, the Medical Exercises. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 X Yes 2 No Director BALTIMORE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 2229 MADISON AVENUE 21217 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married BLACK 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOME IMPROVEMENT PLUMBER 8th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EMMA BROCKTON JULIUS BROCKTON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2229 Madison Ave., Baltimore, Maryland 21217 Hilda Greene Brockton/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State KING MEMORIAL PARK 04-24-04 BALTIMORE, MARYLAND <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Foregral & The Live See 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Kouw 1206 W NORTH AVENUE Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metistalia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Due to (or as a consequence of). Examiner Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): the attending physician P.O. Box 68760 Physiclan/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 99 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Man r of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To tha Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) 29c. License number 4-20-04 D 17537 em 23a) (Type, Print) 1600W MOUNT Boyd Are Balto 2/2/ 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) DAILSHINV S. SALUMM) (600W MC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 2 2 2004

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 6130PM April 2004 HAROLD BROWN 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner of Bastimore Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1፟፟M 2□F MARYLAND Director 220-20-6357 75 Dec. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1XXYes 2 □ No BALTIMORE MARYLAND N/A Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Itams 23a or 21216 U.S.A. 2918 ALLENDALE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Inportant: If item 27 is marked othar than "natural", or itar may lajury or other traumetic event, the Medical Examinat 2008. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MERCHANT SEAMON SEAMON 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MAMMIE DRUMMER FRANK BROWN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2918 Allendale Rd., Baltimore, Maryland 21216 Juanita Brown/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State DRUID RIDGE CEMETERY 04-21-04 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Refujces Licenses 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Hour 1206 W NORTH AVENUE 23a. Part1. Her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiomyopstu **Physician** 10 41 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under vin . Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed physicien and the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Stage Discase 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No 1 Yes 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 🔼 No 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 □ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month. Dav. Year) RES-OC Bradauskarte MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) .0 BRADHUSKAITE BALTIMORE HD SINAI HOSPITAL GITANA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 2 2004 Registrar

BROWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Harry Oscar Beard 19, 4:20 P April 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bel Air Harford 514 Mauser Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 11☑M 2□F 86 716-16-8515 Maryland Director Jun. 1917 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, it is Medical Examinat must be notified at Harford Bel Air 1 ☐ Yes 2 X No Maryland **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 514 Mauser Drive 21015 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1√ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specity: White Specify: Completed by 3X Widowed 4 □ Divorced Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. int: If item 27 Is marked other than "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Contracting Company Construction Supervisor 12 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Harry James Beard Hannah Mary Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Beard/Son 514 Mauser Drive, Bel Air, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Hilltop Corp. 4-24-04 Towson, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, MD 23a. Part 1. Ententhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Esophagus **Physician** od Down concreta /Medical Due to (or as a consequence of): **Examiner** Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 \(\subseteq\) Yes 2 \(\subseteq\) No 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2X No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After Hospital or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М Director 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1)1979>

State Registrar

DHMH 17 Rev 1/2001

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Below Rel Buttimere Mel 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard

APR 2 2 2004

31. Date filed (Month, Day, Year)

11 Bon P MM

32. Registrar's Signature

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H			ene 3. No 2004	12509
H	Physici	ian	1. Decedent's Name (First, Middle, Last) Hilda Burchett				-	2. Date of Death	, <sup>Day</sup> 2004 Year	3. Time of Death
	/Medic Examir	cal	4a. Facility Name (If not institution, give str Gilchrist Hospice	eet and number)		4b. City, Town, o	or Location of Dea		4c. County of Death Baltimore	6:25 a <u>№</u>
	Funeral Director		5. Social Security Number 234–46–3467 6. Sex 1	7. Ag	e (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			place (State or Foreign ntry) Virginia
	land Dw		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mary	ctor	MD Baltimore	<u> </u>	White M	arsh				1 ☐ Yes 2 <b>∑</b> No
	h with th	ai Dire	10e. Street and Number 5702 Gunpowder Rd			10f. Zip Code 21162	2		g. Citizen of What Cou USA	ntry?
336	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any njury or other traumatic event, ira Medical Eramical must be rotified at ances.	Completed by Funeral Director	11. Marital Status 12 1 Never Married 2 Married 3. Widowed 4 Divorced	Was Decedent I Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates:	No	Was Decedent of Half Yes, specify Cub	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify White	etc.
1213-0036	within 72 hor ane. than "naturi the Medical E	mpieted	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4or 5	(Give	dent's Usual Occup kind of work done DO NOT use retire Kaging	pation during most of wo d)	rking	Sb. Kind of Business/In Gant & Bend	,
yland z	uld be filed dental Hygie rkad other tic event, II	To Be Co	17. Father's Name (First, Middle, Last) Lenzie Hedrick	0				me (First, Middle, Ma Lambert	aiden Sumame)	
Mary	ind 2 shou aith and M 27 is mai		19a. Informant's Name/Relationship (Type Joyce Burchett-Arno		19b. Mailie 1383:	ng Address (Street 5 Forsyth	and Number or Ri ne Rd Syk	ural Route Number, C Cesville M	City or Town, State, Zip D 21784	Code)
santimore,	Pages 1 a ment of He ant: If item ury or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer  4 ☐ Donation 5 ☐ Other (Specify)	noval from State	20b. Place of Disponsion Commetery, cres	esition (Name of matory or other pla VaLLEY Me	em. 4/2		oc. Location - City or Toulaney Val	
Dall	permit. Departimport		21. Signature of Funeral Society Licensee		1.	2. Name and Addre	ss of Facility CV	ach/Rosedale	ale Funer i e Maryland	21237
	Physician		23a. Part. Effect the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition		the death. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory arrest	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	lue To	multi	- drug re	Sistant	( weak
	acuted tnd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			B401	er ( 1)			
9/00,	cate be executed physicien and the burial-transit	dicai Ex	d	Due to (or as	a consequence of):					
C. Box a		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1  Yes 2 No 9  Unknown	If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of delive Month	ery Day Year
cords, P.	equires that I en signed by ould be deta	þ	Part II. Other significant conditions contri	buting to death but $SC(eN)$		nderlying cause giv		23e. Did tobac	cco use contribute to the	ne cause of death?
ב	n: The law re licate has be r. page 2 sho	Completed	7		2.0			24a. Was an autopsy performe 1 \( \text{Yes} \) 2	d? prior to coi	psy findings available mpletion of cause of
Sion of Vital	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as	tlon: To Be	1 105 21110	pital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	y 28b. Time of	28c. Injur Wor	er: 4□ Nursing F	ath   Check only one   Home 5   Residence 28d. Describe how		1) Hospice
	al or Atter s after dea il Dirsctor ed In by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, str c. (Specify)			28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	hs Hospit in 24 hour he Funera pletely fille	edicai (	29a. Certifier (Check only one)  1 X Certifying Physic 2 Medical Examine	ien: To the best of : On the basis of and manner sta	examination and/or in	n occurred at the tirvestigation, in my o	ne, date and place pinion, death occu	e, and due to the caus urred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier  M - Anthony	Alles	mo	29c. Licens	CAC	11	Date signed (Month,	7006
	1/1		30. Name and address of person who com	mc 67	eath (Item 23a) (Type,	Print)	(+ Bso.	lto md	21204	
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2. 2 2004		ar's Signature	Sports		, , , , ,		

		Ап	end Item #8,per FH,0	3831,5/13/0	-	•	artment of F			Reg. No. 2	004 1251
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle Anna M. 4e. Facility Neme (If not institution 1203 Hilldale	Barr	nhart number)			4b. City, Town, or L Rosedale	9	dc. County Balt	imore
	Funeral Director		5. Social Security Number 220 07 0384	6. Sex 1 □ M <b>XX</b> F		S. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 5/30/1	th y, <i>Year)</i> 920	9. Birthplace (State or Foreign Country) Maryland
	a-f ahow	tor	Usual Residence of Decedent  10a. State 10b. County  MD Baltin	ore		osedale					10d. Inside City Limits 1 ☐ Yes
	3a or 28	il Dire	10e. Street end Number 1203 Hilldale A	Venue			10f. Zip Code 212	227		10g. Citizen of V	Vhet Country? SA
0050	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. The Mental I, or items 23a or 28a-f ahow any injury or other traumatic event, I'm Medical Examination must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was De Armed F	2⊠ No Sive	Н	Was Decedent of H f Yes, specify Cuba	ispenic Origin? (Sp	pecify Yes or No Rican, etc.)		e - American Indian, sk, White, etc. '' White
0-61717	d within 72 ho piene. r than "naturi tre Medical I	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)		lent's Usuel Occup kind of work done o DO NOT use retired ing Guard			16b. Kind of Bu Baltimor Police F	re County
Jama	uld be filed Mental Hyg irked other itic event,	To Be C	17. Father's Name (First, Middle, Unk Biscoth					18. Mother's Nam Emma Co		Maiden Surnam	Θ)
Mai	nd 2 sho alth and 1 27 is me r traume		19a. Informant's Name/Relations Susan Brown D	<sub>hip (Type, Print)</sub> aughter			g Address <i>(Street</i> Hilldale			-	
illione,	Pages 1 e lent of Hez nt: if Item iry or othe		20a. Method of Disposition 1   ☐ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		20b. n State Ga	Place of Dispos	sition <i>(Name of</i> natory or other place f Faith (	ce)	Date 4/21/04	20c. Location -	City or Town, State
Dall	permit. Departmine importa any inju		21. Signature of Funeral Service	Licensee	$\overline{\Omega}$	12	. Name end Addres 211 Chesa	ss of Fecility Cv.	ach/Rose e Roseda	edale Fu ale, Mar	meral Home yland 21237
	Physician /Medical Examiner	er	23a. Part T. Enter the disease, or shock, or heart failure. List Immediate Ceuse (Final disease or condition resulting in deeth)				er the mode of dying by the mode of dying by the mode of the mode				Approximate Intervel Between Onset and Death
,0070	ificete be executed physician end es the burial-trensit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b		or es e consequ					
00 40	n certifice inding ph use es th		resulting in death) Last	d							
7.7.	v requires thet the death certif been signed by the ettending should be deteched for use e.	y Physician/M	Pert II. Other significant condition	ons contributing to	death but not re	sulting in the un	nderlying cause giv	en in Part I.		_	ntribute to the cause of death?  3 Probably 4 Unknown
	law requires as been sign 2 should be	Completed by							24a. Was perfo	an autopsy med?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?
5	sicien: The law s certificate has b director, page 2 s	Be Con	25. Was case referred to medical					26. Plece of Deal	1 □ \		1 ☐ Yes 2 ☐ No
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours effer death.  Within 24 hours effer death.  To the Funeral Director. After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be deteched for use as	욘	exeminer?  1 Yes 2 No  27. Manner of Deeth  1 Natural 5 Pendin  2 Accident investig	g 28e. Dete	Inpatient 2 [ e of Injury onth, Day Year)	ER/Outpetient 28b. Time of Injury	28c. Injun Worl	er: 4□ Nursing Ho	ome 5. 4Resid	dence 6 Othe	
	ai or Atter s efter dea il Director ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could determ	ined 200. Plac	e of Injury - At h	nome, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	er or Rural Route Number,
	the Hospit in 24 hour he Funers pletely fills	edicai	(Check only 2 Medical one)	and ma	e best of my known basis of examination of examination of the stated.	owledge, death ation end/or inv	occurred at the timestigation, in my or	ne, date and place, pinion, death occur	and due to the or red at the time, or	cause(s) and mad date and place, a	nner es steted. and due to the ceuse(s)
	with To t	Σ	29b. Signature end title of certified	11111	lace -	110	29c. License	1/		1 11	(Month, Day, Year)
,	10		30. Name end eddress of person Tom Edmands	who completed cau	use of death (Ite	m 23e) (Type, F	Print)	, (te.31)	Baltim	ore M.	9,2004 D21237
	Sta Registr		31. Date filed (Month, Day, Year)	Serena.	Registrar's Sign	Spars	KN	)	1,1	7	

DHMH 16 Rev 6/95

			For State Registrar	State o	f Maryland		artmen rtificate			and M		giene 200	L	12511
	Physicia	an	1. Decedent's Name (First, Middle,	_ast)				ľ			2. Date of Dea Month	ith Day Ye	ar	3. Time of Death
	/Medic		Ann Blom					-			April			2:35P M
	Examin	er	4a. Facility Name (If not institution, g		mber)				Location o	f Death		4c. County of E		
			Gilchrist Hospic  5. Social Security Number 6	Sex	7. Age (In yrs. las	t birthday)	If Under	Tows o	O <b>n</b> If Under :	24 Hrs.	8. Date of Birth		Birthol	nore ace (State or Foreign
	-uneral Director		051-26-8623	1 □ M 2/CXF	89	-	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Nov. 5,	1917 Ne	Count the	rlands
þ			Usual Residence of Decedent		40.00.0									
arylar	show	<u>.</u>	10a. State 10b. County		10c. City, 1		cation						10	0d. Inside City Limits 1 ☐ Yes 2√☐ No
h M	28e-1	Director	MD Balti	more	Ca	rney	10f. Zip	Codo				10g. Citizen of Wha	Count	
with	a or				_		TOI. ZIP		21234			•		•
leath	ns 23	Funerai	8800 Walther BJ	12. Was Dec	edent Ever in U.S.	13.1	Was Deced			gin? (Spe	cify Yes or No- Rican, etc.)	United 14. Race - A	America	an Indian,
affer	r iter	풀	1 Never Married 2 Married	Armed Fo 1 ☐ Yes If Yes, Gir			_	_		, Puerto F	Rican, etc.)			
ours a	ral', c	d by	XXWidowed 4 □Divorced	Year or D	ve lates:		1 ☐ Yes	21X NO	Specify:			Specify: W	hit	e
72 h	natu	Completed	15. Decedent's (Specify only highest)			16a. Dece (Give	dent's Usua kind of wor DO NOT us	il Occupa rk done d	ation furing most	of workir	ng	16b. Kind of Busine	ess/Ind	lustry
within	than	ם	Elementary/Secondary (0-12)	College (	1-4or 5+)		Homema		,			Domesti	c	
1 pel	Hygie ther ant, II	ပို	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	(First, Middle,	Maiden Sumame)		
od b	ked c	O.B.	Joseph Speyer						Sar	ah Ka	at			
shou	S mar		19a. Informant's Name/Relationship	(Type, Print)	1	19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	l Route Numbe	r, City or Town, Sta	te, Zip	Code)
and 2	n 27 i er tra		John Blom (Sor	1)			Shanı				-	, Marylan	d	21213
98 1	of He if item or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3	☐Removal from	State 20b. Plac	e of Dispo netery, crer	osition (Nan matory or o	ne of ther place	e) 4/2	3/04	ate	20c. Location - City	or Tov	wn, State
Pag	tent:		`4 □Donation 15 □Other (Spe	cify)	Balt	imore	-Wash	ningt	ton C	remai	tory	Laurel,	Mar	yland
ermit	Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, Ite Mudical Extrait at minist ke notified at once.		21. Sign turn Funeral Service Lic	censee			2. Name an Lller-				al Home	, Inc.		
			23a. Part1. Enter the disease, or or	amplications that of	aused the death	Do not ent	15 Be	elair	r Roa	d Ba	altimor	, Inc. e, Maryla	nd	21206 Approximate
Ξ.			shock, or heart failure. List or Immediate Cause (Final	ly one cause on e	each line.							1001,		Interval Between Onset and Death
	ysician Medical		disease or condition resulting in death)	a	(or as a consequer	nce of):	70 10	nav	100	PM	marc	1	-	1car
Ex	aminer				(5. 40 4 55.1554						J			
T.	9.0	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to	(or as a consequer	nce of):								
acuted	ind	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		- 0								
	hysician and the burial-transit	ai Ey	rosuling in asain, East	Due to	(or as a consequer	nce or):						•		
OF VICE THE LEW REQUISES that the death certificate be executed	physics the l	dicai		d									+	
Certif	signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnanc							23d. Date of	deliver	ry
death	e atte	icia	in the past 12 months? 1 ☐ Yes 2 █ No	4☐Pregr	ointh 2 ∏Fetal de nant at time of deat		Ectopic pr Dther (sp			<del>.</del>		Month	1	Day Year
i fe	by th	hys	9 □ Unknown	9□ Unkn	own					2-	1	41		
es the	gned be de	by F	Part II. Dther significant condition	s contributing to d	eath but not resulti	ng in the u	nderlying c	ause give	en in Part I.		1	bacco use contribut		No.
requir	pinou	Completed										_	] Proba	
e law	has b le 2 si	mple									24a. Was a autop perfor	sy prior	to com	osy findings available apletion of cause of
ב ה ה	r, pag										1 Yes	20X/No 1 🗆		2 ☐ No
y II	certii	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 № No	Hospital:	Inpatient 2□EF	2/Outpation	nt 3 DC	Othe	or.		(Check only or ne 5 ☐ Resid		2nnnih.	hospice
	er this eral d	H .	27. Manner of Death			8b. Time of		8c. Injury Work				ow injury occurred	эроспу	1005010
g ig.	ath. or: Aft	atlo	1 Natural 5 Pending 2 Accident investiga	tion	un, Day Toan	injury	М		Yes 2 1	No				
Y Atto	irecto	Certification:	3 Suicide 6 Could no 4 Homicide determin	288. Place	of Injury - At homing, etc. (Specify)	e, farm, str	reet, factory	, office		2	28f. Location (S City or Tow	Street and Number o n, State)	r Rural	Route Number,
ojtal C	urs af erei D illed i			Dh. daine T. d										
To the Hospital or Attending	within 24 hours after death.  To the Funerel Director: After this certificate has been si completely filled in by the funeral director, page 2 should	edical	29a. Certifier  (Check only one)  (Check only one)	taminer: On the b	a best of my knowle asis of examination oner stated.	n and/or in	n occurred vestigation	at the tim , in my op	inion, deal	d place, a th occurre	ed at the time, o	cause(s) and manne date and place, and	r as sta due to	the cause(s)
To th	withir To th comp	Me	29b. Signature and title of certifier	Л	. 0		-	License	1 20	30		29d. Date signed (M	1 0	
	1		Hera	1	W			2	185	05	1	parci	T o	1004
	10		30. Name and address of person with the state of the stat	no completed cau	se of death (Item 2)	(Type,	Chan	les	8+	Ba	ltenn	e 402	12	04
	Sta Registi		31. Date filed (Month, Day, Year)  APR 2 2 2004		Registrar's Signatur	post								

ORIGINAL.

rn rn	11940		rice	State of M	Aanulan	d / Den	artman	t of H	calth:	and M	lontal Hv	niene .	egible.		
			1 - State	State of N	iai yiai i	Сел	rtificate	e of E	Death	and w	ientai riy	Reg. No.	2004	12	513
20			Ragistrar  1. Decedent's Name (First, Midd	le, Last)					`		2. Date of Dea	ath		3. Time o	
	Physici /Medic		Ida V. Cocke	rham							Month March	08	2004	2:08	РМ
	Examin		4a. Facility Name (If not institution	-	r)		4b. City,	Town, or	Location	of Death		4c. Co	unty of Deat	h	
	y.		1202 Beach Pro			t46'-46 t- 1	Cu:	rtis	Bay If Under	24 Hrs	2.5	1	e Aru		
	Funeral Director		5. Social Security Number 219-30-4357	6. Sex 7. A	77	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt Sept 2	γ <sub>ea</sub> ()92	26 M	hplace (State untry) aryland	o <i>r Foreig</i> n
	ס		Usual Residence of Decedent												
	anylan ahow	_	10a. State 10b. Count		10c. City	y, Town or Lo								10d. Inside (	Sity Limits S 2 No
	Abe Ma	Director	MD Anne	Arundel		Cur	tis B					10a Citize	n of What Co		-X-
	with with I be or 3	וסו	1202 Promen	ada Road			TOI. ZIP	212	26			-	JSA	dility:	
	within 72 hours after death with the Maryland ane. then "natural, or Items 23e or 28e-f ehow the Medical Examinat must be notified at	Funeral	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.	S. 13.	Was Deced	ent of His	spanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)	- 14.	Race - Ame Black, White		
98	or Its	y Fu	1 Never Married 2 Ma	rried 1 Tes 2 2	No		1 ☐ Yes 2				i would be only			hite	
21215-0036	hours tural',	ed by	3 \( \Overline{	d Year or Dates  nt's Education	i: 	16a Dece	dent's Usua	I Occupa	tion			16h Kind	of Business/	Industry	unk
7.	n na Nedic	plet	(Specify only high Elementary/Secondary (0-12)	est grade completed)  College (1-4o	r 5+)	(Give	kind of wor DO NOT us	k done d	uring mos	t of worki	in <i>g</i>	100.11110	0. 500000	outly	diik
212	filed with Hygiene other the	Completed	12	4			bi	11er							
Maryland	be file	Be	17. Father's Name (First, Middle Pantaleon H								(First, Middle,				
3	should be to the Mental I was marked or umatic even	2	19a. Informant's Name/Relation			10b Mailie	na Address	/Street a			neid A.			Tin Code)	
S	and 2 sl ealth an n 27 le r		Edward Richard								Salonga			up Code)	
ē,	of Hea item		20a. Method of Disposition			lace of Dispo emetery, crea	sition (Nam	ne of			Date	<del></del>	ion - City or	Town, State	
Ē	Pages nent of ant: If it		1 ☐ Burial 2 ☐ Cremation  4 🕅 Donation 5 ☐ Other (		7	,,							,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any rightry or other traumatic event, Ita Medical Examinat must be notified at ODGe.		21. Signature of Funeral Service Ronal d	655 W.		imore	Street								
			23a. Part1. Enter the disease, of	or complications that caus	ed the death	n. Do not ent	altimo er the mod	ore,	MD , such as	2120 cardiac	1 or respiratory ar	rest,		Approxima	ite
E	Physician		shock, or heart failure. Lis Immediate Cause (Final disease or condition	ПАДЕДЕЛ	MOTUE	ATHER	ROSCLE	EROTI	C CA	RDIO	VASCULA	R DIS	EASE	Interval Be Onset and	
	/Medical		resulting in death)	Due to (or	OMPL I	CATED uerice of):	BY RI	GHT	ANKL	E FR	ACTURE				
Fase	Examiner		Sequentially list conditions,	b. — Due to (or a											
	ted	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	de lo lo lo la la	is a consequ	uence oi):									
Ć.	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or a	is a consequ	uence of):									
760,	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	cal		d											
89 )	leath certificate l attending physi	Physician/Medi	IF FEMALE:												
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No	23c. If yes, outcom 1 Live birth 4 Pregnant	2 Fetal	Ideath 3[	Ectopic pre					230	I. Date of deli Month	very Day	Year
o.	that the de ed by the detached	yslo	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown		52	200101 (30								
٥,	res that igned b be deta	by Pi	Part II. Other significant condit	ions contributing to death	but not rest	ulting in the u	ndertying ca	ause give	n in Part I		23e. Did to	bacco use	contribute to	the cause of	death?
ord	w require been sig should b	ted !	CTRRHOSIS								1 🗆 Y	es 2 80	lo 3∐Pr	obably 4	]Unknown
Records,	law r nas be a 2 sh	Completed	DIABETES	MELLITUS							24a. Was autop	SV	prior to d	topsy findings completion of	available cause of
al H	r. The		OBESITY								1 <b>20</b> Yes		death?	2 No	
of Vital	Physician: this certificanal director,	Be c	25. Was case referred to medic examiner? 1 XYes 2 □ No	Hospital:	*i 0 🗔	ER/Outpatier		A Othe			(Check only o		1		2000
	g Phy er this eral d	n; To	27. Manner of Death	28a. Date of In				a   Bc. Injury	at at	-	ne 5 ☐ Resid 28d. Describe h			iny) at E	cene
ion	ttending death. stor: Aft / the fun	atlo	A A A A A A A A A A A A A A A A A A A	tigation found 3-8		28b. Time of Injury f 2:08F	Ourid	Work 1 □ Y	es 2∑X	No	SUBJEC	CT FEI	L		
Division	f or Attending after death. Director: After I in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mised 200, Flace of I	njury - At ho etc. (Specif)	ome, farm, str	eet, factory	, office			28f. Location (S City or Tow	m, State)			
Ω	pital c	Ce	CO- Carrier 1 Carrier	ing Physician: To the be	HOMI			- A Ab - Aires	- 4-1-	3	1202 BEAC				
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 ☐ Certify  (Check only one)  Check only one)	I Examiner: On the basis and manner	of examina	tion and/or in	vestigation,	in my op	e, date ar inion, dea	ith occurr	and due to the d ed at the time, d	date and pla	o manner as ace, and due	to the cause(	(s)
	To the within 2 To the complet	×	29b. Signature and title o certific	9 //			29c	. License	number			29d. Date s	igned (Month	Day, Year)	
				11 1	12			O.C	м.Е.			March	21, 2	2004	
			30. Name and address of person	who completed cause of	death (Item			n St	reet	Ral	timore,	Mars	land 2	1201	
	Sta	ite	31. Date filed (Month, Day, Yea	) 32. Regis	strar's Signa	turo é	£				CHICLE)	. илг у			
	Registr		APR 2 2 2	1004 Setes	ممسر	P /	spor.	es							

DHMH 17 Rev 1/2001

			For State Registrar		State of	Maryland		artmen rtificate				lental Hy	/giene	/ 11 11 11	12514
	Physici /Medic		1. Decedent's Name Florence	(First, Middle, I Cantem								2. Date of D Month April	eath Da	y Year 2004	3. Time of Death
)	Examir		4a. Facility Name (If  Mariner H	balth of	Bethesda			В	ethes				4c	. County of Death Mantgame	ry
Ĺ	Funeral Director		5. Social Security No. 160–20–2125 Usual Residence of	5	Sex 7	. Age (In yrs. Ia:	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, D July 1			place (State or Foreign intry) PA
	Maryland	tor	10a. State MD	10b. County	ntgamery	10c. City,	Town or Lo	cation	Rock	ville					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the 23s or 28s	ai Direc	10e. Street and Num 4862 CLo	<sup>nber</sup> ister Dri	ve			10f. Zip	Code <b>208</b> 5	2			10g. Cit	tizen of What Cou	intry?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene item 27 is marked other then "naturel", or Items 23s or 28s-f show other treumatic event, If a Modical Eventual artimust be inclifted at	d by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 🌠 Widowed		12. Was Deced Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Dat	es? XXNo		Was Deced f Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ameri Black, White, Specify:	
21215-(	id within 72 h giene er then "natu , the Medical	Completed	(Special Elementary/Second 12		Education grade completed) College (1-4	lor 5+)	16a. Deced (Give life.	kind of wor DO NOT us	k doné d e retired,	luring mosi		ing	16b. K	ind of Business/Ir Nursi	
Maryland	should be filed ind Mental Hygi s marked other umatic event, II	To Be (	17. Father's Name ( Abe Weiss		st)					18. Mothe	r's Name	(First, Middle Rose Z			
	nd 2 shou alth and N 27 Is ma		19a. Informant's Na Robert Can					_				I Route Numb		or Town, State, Zij	o Code)
Baltimore,	permit. Pages 1 and Department of Healt Importent: If item 2 eny injury or other once.		20a. Method of Disp 1 Burial 2 C	Cremation 3	Removal from St	cen	ce of Dispo netery, crer y Socie	natory or ot	her place	y Apr		) ate , 2004		pwood, PA	
Balti	permit. Departr Importe eny inju		21. Signature of For	neral Service Lic	ensee Victor	P. Doda,		Name and harles 1501 Ea	5 L. S	Steven	s Fun	eral Hom , Baltim	e, In ore M	C. D 21230	
8760,	Physician and whysician and physician and physician and the printi-transit	Ical Examiner	shock, or hear Immediate Cause (I disease or condition resulting in death)  Sequentially list contains a sequentially list contains a sequentially list contains a sequentially list contains a sequential list cause. (Disease or it that initiated events resulting in death) L	ritaliure. List on Final no ditions, macrate ritying njury	b. CE Cua to (or	SEIZ as a conseque  KEAC as a conseque as a conseque	LURE ince of): DUAS		315	ORD	ER				Approximate Interval Between Onset and Death
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 if Yes 2 5 9 Unknown	months?		h 2 ☐ Fetal d nt at time of dea	eath 3	Ectopic pre			332333			23d. Date of delive Month	ery Day Year
	w requires that been signed b should be deta	by	Part II. Other signifi	cant conditions	contributing to dea	th but not resulti	ing in the ur	nderlying ca	iuse give	n in Part I.		23e. Did	4/	\ /	he cause of death?
al Records,	The ate ha	e Completed	25. Was case referr									1 Yes	psy ormed? 2 No	24b. Were auto prior to co- death? 1 \( \subseteq Yes	psy findings available mpletion of cause of
of Vital	d is	To B	examiner?  1 Yes 2	No	Hospital: 1 Inp		R/Outpatien 8b. Time of		A Othe	r: 4 Nui	rsing Hon	(Check only ne 5 Resi	dence 6	6 □Other (Specify	y)
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigat 6 Could not determine	be 28e. Place of	Day Year) Injury - At hom, etc. (Specify)	Injury	М	Work	? 'es 2 □ N	40		Street an	d Number or Rura	d Route Number,
	To the Hospital or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier (Check only one)	1 Certifying I	Physician: To the base	is of examination	edge, death n and/or inv	occurred a estigation,	it the time	e, date and inion, deat	d place, a h occurre	and due to the ed at the time,	cause(s) date and	and manner as si place, and due to	tated. o the cause(s)
	To the within To the comple	Me	29b. Signature and	title of certifier		, 1	1.0	1	License	766	0		1	e signed (Month,	1.
			30. Name and address	Gos	o completed cause	of death (Item 2	3a) (Type, 1	Print)	UE	PIK	Œ	Rock	WIL	LE MD	20852
	Sta Registr		31. Date filed (Monti	h, Day, Year) PR 2 2 20	32 Reg	istrar's Signatur	dos	de							

CANTORIVAN

			1 - For Stata Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of H tificate of L			ene g. No 20 (	) 4 12	515
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time o	of Death
	/Media	cal	James 4a. Facility Name (If not institution, give str	and aumber)	Coffe	<b>≙Y</b> 4b. City, Town, or	Landing of David	April	1	004 3:39	РМ
	Examir	ner	Johns Hopkins Hos			Baltimo:			4c. County of		
	Funeral		Social Security Number 6. Sex	7. Age (	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State	or Foreign
	Director		210 30 1012	1 2□F	24 Yrs.	WICHUIS Days	Hours Min.	8-18-7		Md.	
	land ow		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside C	City Limits
	Mary R-f sh	tor	Md. NA		Baltim	ore				1XX Yes	2 □ No
	or 28	Olrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh		
	s 23a	rai	1509 Mullikin Ct.	W- 8		21231			USA		
10	tter de r Itam iner	Funeral Director	11. Marital Status 12  1 Typever Married 2 Married	. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 2 No	er in U.S.   13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spi n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		American Indian, White, etc.	
936	al', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I□Yes 2∏ No	Specify:		Specify:	Black	
5-0	be filed within 72 hours after death with the Maryland tall Hygiene. Id other than "natural", or Itams 23a or 28a-1 show avant, the Marifal Exeminer must be mailthed at	Completed	15. Decedent's Educa (Specify only highest grade	tion completed)	(Give	lent's Usual Occupa kind of work done d	uring most of work	ing 1	6b. Kind of Busi	ness/Industry	
121	within ene. than	duuc	Elementary/Secondary (0-12)	College (1-4or 5+)	Roof	OO NOT use retired)			Varies	3	
d 2	illed Hygi othar ant, I	Be Co	12th grade 17. Father's Name (First, Middle, Last)		ROOI		18. Mother's Name	(First, Middle, M			
/lar	2 should be filed within and Mental Hygiene. is markad othar than aumatic avant, Ibe M.	To B	James	Edward	Ross	Jr.	Susann		Coffe	ey	
Maryland 21215-0036	ges 1 and 2 should t of Health and Men If item 27 is marka or othar traumatic		19a. Informant's Name/Relationship (Type	. Print)		g Address (Street a				ate, Zip Code)	
	1 and Health em 27 thar t		Brenda Ross Au 20a. Method of Disposition			N. Bethel				231 ty or Town, State	
nor	ages ant of nt: If it y or o		Burial 2 Cremation 3 Rer	noval from State	20b. Place of Dispo- cemetery, crem						
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar tra <u>once</u> .		21. Signature of Funeral Service Licensee	n2 -		hedral Cer . Name and Address			altimor ore, Md		
<u> </u>	Depar Impo any ir		I Francis	Tens	$\gtrsim$	March F.		1101 E	. North	Ave.	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c	ple qu	VISINGT C			et,	Approxima Interval Bet Onset and	tween
8760,	icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a o							
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of 1□Live birth 2 { 4□Pregnant at tim 9□ Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of Month		Year
rds, P	w requires that been signed should be det	by	Part II. Other significant conditions contr	buting to death but r	not resulting in the un	derlying cause giver	n in Part I.	23e. Did toba 1 ☐ Yes	ø	ite to the cause of c	death? Unknown
Records,	The law reate has bee page 2 sho	Completed						24a. Was an autopsy performe	prio dea	re autopsy findings r to completion of c th? Yes 2 \( \text{No} \)	available ause of
Vital	Physician: T this certificat ral director, pa	Be (	25. Was case referred to medical examiner?	.9.1			26. Place of Death				
of	Physic this cral dir	2	1 XYes 2 No No 27. Manner of Death	pital: 1 ☐ Inpatient 28a. Date of Injury	2X ER/Outpatient 28b. Time of	3 □ DOA Other	4   Iduising Hor	ne 5 🗆 Residen		(Specify)	
0	Attending I r death. actor: After by the funer	tion	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Y	ear) Injury	Work?			t was	Shot	
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, stre		2	8f. Location (Stre	et and Number of	or Rural Route Num	iber,
Ö	ital or is afte ral Dira led in b	Cert	Tal Homoles	Dullding, etc. (	street		ll.	1500 block		LAMORE 1	4D
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier  (Check only one)  1 Certifying Physic 2 Medical Examine	: On the basis of ex	amination and/or inv	occurred at the time estigation, in my opi	e, date and place, a nion, death occurre	and due to the cau and at the time, date	se(s) and manne and place, and	or as stated. due to the cause(s	;)
	vithin on the omple	Mec	29b. Signature and title of certifier	and manner stated	J.	29c. License	number	290	l. Date signed (A	fonth, Day, Year)	
)	- > - 0		Jasha O Sha	user 1	un	C	.C.M.E.	A	oril 20,	2004	
	3		30. Name and address of person who com	1 0		Print)			·		
	Sta	to	31. Date filed (Month, Day, Year)	\$2. Registrar's	0'	Penn Str	eet, Bal	timore, l	Marylanc	1 21201	
	Registr	-	APR 2 2 2004	Benjus	19 14	porks					

		For State Registrer			and / Dep		t of H	lealth a	and M	lental Hyç	_		12516
		1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea		Year	3. Time of Death
Physici /Medi			Ja	mes E	. Cour	sey				Month April			7:00 A M
Examir		4a. Facility Name (If not institution, g	ive street and n	umber)		4b. City,	Town, o	r Location	of Death		4c. Coun	ty of Death	
		7601 Meadow Way						nda1k			Bal	timo	
Funeral Director		5. Sociat Security Number 6. 218-12-2767	Sex 1⊠M 2□F	7. Age (In y	rs. last birthda Yrs.	Months		If Under Hours	Min.	8. Date of Birth (Month, Day July 5	, Year) 1924	9. Birth Cou Ma	plece (State or Foreign ntry) aryland
pu »		Usual Residence of Decedent  10a. State 10b. County		100	City, Town or	Location				-	<del></del>		10d. Inside City Limits
aryla ahov	5			100.	Oity, rown or	LOCATION	_	2 22					1 □ Yes ŽŽ No
Ne W	Director	Maryland Bal  10e. Street and Number	timore			10f. Zic		ndalk			10g. Citizen of	What Cou	otn/?
with	늅					101. 21	, 0000	2122	2		-	d Sta	•
ss 23	era	7601 Meadow Way	12 Was De	cedent Ever in	n U.S.   13	L Was Dece	dent of H			ecify Yes or No-		ice - Ameri	
fter d	Funeral	1 ☐ Never Married 2 ☐ Married	Armed F	Forces? 2 ☐ No						ecify Yes or No- Rican, etc.)	BI	ack, White,	etc.
nours a	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or	live Dates: V	IIWW	1 ☐ Yes	2 <b>]</b> k] No	Specify:			Spec	ify: V	√hite
Iffice X IX 13-0030  be filed within 72 hours after death with the Maryland hal Hygiene.  Id Hygiene.  d other than "natural", or Itams 23s or 28s-f show avent, fre Medical Essribiet must be indiffied at	Completed	15. Decedent's (Specify only highest g		1)	16a. Dec	edent's Usua	al Occup	ation	st of work	ina	16b. Kind of	Business/Ir	ndustry
thin thin	nple	Elementary/Secondary (0-12)		(1-4or 5+)	1	DO NOT u		1)					
ygien th	S		5 Ye	ars	E	ducate	or	10.11-11-	- de Na	· /5: • • • • • • • • • • • • • • • • • •		cation	1
d be file	Be	17. Father's Name (First, Middle, La								e (First, Middle, ret Dow		ime)	
should and Men marke umartic	2	George C. Cours			105.11-		(0					- Ch.4- 7:	- 0-1-1
Man d 2 sh th and 7 is m traum		19a. tnformant's Name/Relationship Sharon E. Cours								al Route Numbe Drive Co			21046
IOTE, MISTYIGITIC ZIZIS-0050 ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or itams 23s or 28s-1 show or other traumatic avent, the Medical Examples must be invitibled at		20a. Method of Disposition		200	b. Place of Dis cemetery, co	position (Nai	me of	1	- (	Date	20c. Location	- City or T	own, State
Pages nent of nt: If i		15☐Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Special Control of Contr							. 4/	21/2004	Crown	nsvill	Le, MD
DESILITIONE, INITIONE, INITIONE, INITIONED PARTHAUS DEPARTMENT OF Health a Important: If item 27 is any injury or other traonics.		21. Signature of Juneral Service Lic	ensee	00	Г	22. Name ar Juda – Ri	nd Addre	ss of Facili	ă1 н	ome of 1	O <b>u</b> ndalk	c, Inc	· ·
0 80E 8 8		delogon	2.10	eec		922 W	ise	Ave.	Dun	dalk, M	aryland	212	
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	plications that y one cause on	caused the deach line.	eath. Do not e	nter the mod	de of dyin	ng, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Physician		tmmediate Cause (Finat disease or condition	a Me	tastatio	c Panc	reutic	Cu	ncer					2 months
/Medical Examiner		resulting in death)	Due to	o (or as a cons	sequence of):								
LAdiminer		Sequentially list conditions,	b	o (or as a cons	coguence of):								
ped	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	000 10	01 23 2 00113	sequence on.								
y xecul n and al-trar	хаг	that initiated events resulting in death) Last	c. Due to	o (or as a cons	sequence of):								
cords, F.O. BOX 68/00, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	calE		d										
oo			<u> </u>								1		
BOX sath certi	L/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pre		- Totania a					23d. D	ate of deliv	ery
death death of for	Ca	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 F gnant at time of		B⊡Ectopic p □ Other (sp					N	lonth	Day Year
by the	Physician/Medi	9 Unknown											
S, se string greed be de	by	Part II. Other significant conditions	contributing to	death but not	resulting in the	underlying o	ause giv	en in Part	1.				he cause of death?
ecords, law requires t as been signe 2 should be	ted	Diabetes								1 1	es 2 No	3 L Pro	bably 4 dunknown
law r	Completed									24a. Was autop	SV	prior to co	opsy findings available ompletion of cause of
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Or VITA Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				0.1		e of Deat	h (Check only o	ne)		
Physi Physi rthis c	2	1 Yes 2 No	1		ER/Outpat					me 5 Resid			fy)
Jing F	lon	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat		e of Injury onth, Day Year	r) 28b. Time Injun	M	28c. Injur Wor	yat k? Yes 2.⊟		28d. Describe h	ow injury occi.	irred	
LIVISION  Tor Attending after death. Director: After In by the fune	icat	3 Suicide 6 Could not	be 390 Play	ce of Injury - A	At home, farm,			163 2	1110	28f. Location /S	treet and Nun	ber or Run	al Route Number,
DIVISION of a control of a cont	Certification;	4 ☐ Homicide determine	buit	ding, etc. (Sp	ecify)		,,			City or Tow	m, State)		
UNISION OF VITAL MEGINERS TO THE HAS TO THE HAS WITHIN 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical Ex	Physician: To the aminer: On the	he best of my basis of exam	knowledge, de nination and/or	ath occurred	at the tir	ne, date ar	nd place, ath occur	and due to the o	ause(s) and n	nanner as s	stated. o the cause(s)
thin 2 the I the I	Med	one) 29b. Signature and title of certifier	and ma	inner stated.		29	c. Licens	e number			29d. Date sign	ed (Month	Day Year)
Tw To		amit )	Jepli.	1	1D			5 OX	31		04/1		
not		30. Name and address of person wh		- 1	· P		170	- 000	/		07/1	7 ( 00	7
2		Amit Golding 3	HBMC-MI	45P et 1	Bayview	Hedical	Center	4940	o Eus	tern Ave.	Bultime	ve, M	0 21224
	ate	31. Date filed (Month, Day, Year)	32.	Registrar's Si	ignature	las	11						
Regist	rar	APR 2 2 2004	Den		10	good	N						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 100 1 - State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Thomas Joseph Collins April 18, 2004 7:38 P M /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 4116 Hamilton Avenue Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☑ M 2 ☐ F Months Days Hours Min Yrs. 61 Director 368-46-3817 1942 Michigan June 6. Usuat Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County iem 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 □ No Director Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4116 Hamilton Avenue 21206 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ 12 any injury or other traumatic even. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Vietnam 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No White Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementary/Secondary (0-12) Coltege (1-4or 5+) Administrator 12 State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James J. Collins Marjorie J. Mangold 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Margaret A. Collins - Wife 4116 Hamilton Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 ☑ Other (Specify) Entombment Gardens of Faith April 24,2004 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Baltimore, Maryland 21214 Alan Birch Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Finat Priysician PANCREATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine requires that the death certificate be executed use as the burial-transit been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 20 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Y Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Naturat 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signal 29c. License number 29d. Date signed (Month, Day, Year) D44560 4/19104 MO 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 120 SISTER BIERRE OB

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 2 2004

32 Registrar's Signature

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ysician Medical	Decedent's National		William Fr		hitten			· Vi	1	14 <sup>Pay</sup> 20		3. Time of Death 3:11 A
aminei	HOWARD	COUNTY	n, give street and numb GENERAL HO	SPITAL		C	OLUM			HOWA	ty of Deeth	
ral tor	5. Social Security 215-62-	4434	6. Sex 7. 1 □XM 2 □ F	Age (In yrs. las 38	t birthday) Yrs.	If Under 1 \ Months D		f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da October	ay, Year)		lace (State or Foreig stry) shington D C
	Usual Residence 10a. State	10b. County		10c. City,	Town or Loc	ation					1	0d. Inside City Limits
of of	Maryland		Howard				Ellic	cott City				1 ☐ Yes 2 ☐ No
i Dire	10e. Street and N 9954 Oa					10f. Zip Co	ebc	21042		10g. Citizen of	What Coun U.S.	
by Funeral Director	11. Marital Status 1 Never Ma. 3 Widowed	rried 2□ <b>X</b> Marı 4 □ Divorced	If Yes Give	es? ∐XNo		as Deceden Yes, specify		anic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)	Speci	ice - Americ ack, White,	
Completed	(Specification)	ecify only highe	t's Education st grade completed)  College (1-4-2)	or 5+)				on ing most of work rmation Sy		16b. Kind of E		dustry urnalism
To Be C	17. Father's Name		<i>Last)</i> Villiam Chittend	en			18	3. Mother's Nam	e (First, Middle Mar	. Maiden Suma y Ellen Col	,	
	19a. Informant's !	Name/Relations gela Chitte		/ife	19b. Mailing	Address (Si	treet and	Number or Rui	ral Route Numberly, Marylan	er, City or Town	, State, Zip	Code)
	20a. Method of Di	sposition	3 □Removal from Sta	20b. Plac	e of Disposi	ition (Name o	of or place)		Date	20c. Location		wn, State Maryland
1	21. Signature of 5	weral Service	///	101535	22.	Name and A Sla	Address o	of Facility neral Home	e, P.A. Pike Ellico	tt City, MD	21043	
ner	Inmediate Cause disease or conditions resulting in death	(Final ion	Due to (or b.		cation( ce of):				or respiratory at			Approximate Interval Between Onset and Death
cal Examiner	Cause (Disease of that initiated even resulting in death)	r ińjury ts Last	c. Due to (or d.	as a consequen	ce of):							
Physician/Medic	IF FEMALE: 23b. Was decede in the past 1: 1  Yes 2 9  Unknow.	2 months?		2 ☐ Fetal de at time of death	ath 3□E	ctopic pregn Other (specif					ate of deliver	y Day Year
þ	Part II. Other sign	ificant condition	ns contributing to death	but not resultin	g in the und	lerlying caus	e given i	n Part I.	23e. Did to		tribute to the	e cause of death?
et										rmed?	Were autop prior to com death? 1 2 Yes 2	sy findings available pletion of cause of
Completed		rred to medical	Hospital:				Othor		h Check only o	***		
Be	25. Was case refe examiner?	7.14			Outpatient	3□ DOA			me 5 Resid	lence 6 □Oth		
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Be	examiner? 1 X Yes 2 C 27. Manner of Dea 1 Natural 2 Accident 3 Suicide	th 5 ☐ Pendin investig 6 ☒ Could r determ	28a. Date of Ir (Month, I	njury 28 Day Year)  Injury - At home etc. (Specify)  DUNTY GENE st of my knowled of examination	2:50 , farm, stree	a <sup>M</sup> ot, factory, off spital occurred at th	1 ☐ Yes	2 1 No	inknown 28f. Location (S City or Tow	Street and Number, State)  Lane, E	per or Rural  Ilicott	City, MD

State Registrar

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31. Date filed (Month, Day, Year)

APR 2 2 2004

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND ITEM #18 PER FH C831 5/03/04 Mertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 7:03 M Leonice Marie Cummings 200 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 40 City, Tomi,

40 VPE de Grace

11 Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

April 17, 1917 | Nova Scotia Nursing 40Me HIZROA 5. Social Security Number 6. Sex . Age (In yrs. last birthday **Funeral** 1 ☐ M 2 🔀 F 023-03-6606 Yrs 86 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Show ir than "natural", or items 23a or 28a-f show Harford Bel Air Maryland 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 21015 USA 465 Darby Lane death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 €No Specify: Specify: White þ 3√2Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other tha any hiury or other traumatic event, Ital once. Homemaker 11 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Mich Ambrosine Eloi (NA) Babin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice M. Miles/Daughter 465 Darby Lane, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Arlington Nat'l Cem. 4-30-04 Arlington, VA \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Irrhosis 11/2 V 6 **Physician** 10 455 /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Delydralin 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page After this certificate 1 Yes 2 No 1 🗆 Yes 2 0 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after death To the Funeral Director: completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Iw mans D32609 4/16/04

State Registrar Kamnedin

31. Date filed (Month, Day, Year) APR 2 2 2004

DHMH 17 Rev 1/2001

"Unmings

1106

32. Registrar's Signature

Revolution St

· House be Grace MD 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(MA.

Methan.

# DEETZ, DAVID

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Physician	1	1. Decedent's Na David		ile, Last) eetz							2. Date of D Month		av	Year 2004	3. Time of Death
/Medica Examine	, 4	4a Facility Name tella Mari	,			mber)			4	b. City, Town, or Baltim		ath 4	c. Ćounty	of Death	
Funeral Director		5. Social Security 218–68–1		6. Sex 1 → M	2□ F	7. Age ( <i>In yrs.</i> 48	. last birthday Yrs.	If Under 1 Y Months De	ear ays	If Under 24 Hrs Hours Min		Birth Day, Year 1956	•)	Cour	place (State or Foreign htry)
Aeryland f show	ı	Usual Residence 10a. State MD	of Decedent 10b. Count	у	Ŋ/A		ity, Town or L	ocation		Bai	ltimore			1	0d. Inside City Limits 1127 ves 2 □ No
offer death with the Mer offer thems 23s or 28s-f sincer must be notified	DI DI	10e. Street and N 1803 Wick		9				10f. Zip Coo	de	212	30	10g. C	itizen of V	What Cour	ntry?
Baltimore, Maryland 21215-0020  semit. Pages 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" or thems 23a or 28a-f show any Injury or other traumatic event, the Medical Evantiner must be notified at once.	2		s arried 2⊠Ma 1 4 □ Divorce	rried	Was Dece Armed Fo 1  Yes If Yes, Giv Year or D	2 <b>∑</b> No ∕e	J,S. 13.	Was Decedent If Yes, specify ( 1 ☐ Yes 2 ☑		spanic Origin? (: n, Mexican, Pue Specify:	Specify Yes or to Rican, etc.)	No-	Blac	e - Americ ck, White, :: Whi	
1 21215-0( led within 72 hor ygiene. Ner than "natura nt, the Medical	Inpleted	Elementary/Se	15. Decede pecify only high econdary (0-12)	nt's Educati est grade co	College (	I-4or 5+)	(Give	DO NOT use re	one d stired	luring most of wo )	orking	16b. l		usiness/Ind	
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e, Marylan  1 and 2 should be Health and Mental em 27 is marked of	-	19a. Informant's Marie D.	Name/Relation Deetz /		Print)					and Number or F				State, Zip	Code)
Baltimore, semit. Pages 1 ar Department of Hea Department of Hea mportant: If Item in the Injury or other ance.	1		Pisposition 2 ☆ Cremation n 5 □ Other (		noval from	State	cemetery, cre	osition (Name of matory or other remetory	of place	е)	Date <b>Apri</b>	1		City or To	own, State
Baltim permit. Pag Department Important: I any Injury o		21. Signature	Funeral Service	Licensee	Victo	or P. Dox	ar or		Sta	s of Facility Evens Fund rt Avenue				)	
Physician /Medical Examiner		23a. Part1. Ente shock, or h Immediate Caus disease or condi resulting in death	eart failure. Lis e (Final ition	or complicated to only one of all all all all all all all all all al	ions that c	each line.		rer		such as cardia		arrest,		1	Approximate Interval Between Onset and Death
requires that the death certificate be executed requires that the death certificate be executed seen signed by the attending physician and should be detached for use as the buriel-transit and hy Dhyselrian Madinal Evandon	ā	Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated everesulting in death	or injury i	b. – c. <sub>–</sub> d. <sub>–</sub>			or as a conse								
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Vital Rec sicten: The law certificate has t lirector, page 2 s	5											. Yas 2	ENO	10	]Yes 2□No
al a	2	25. Was case refearaminer?  1 Yes 2 2 27. Manner of De  1 Natural  2 Accident  3 Suicide	⊠No eath 5 □ Pend	Hos ing tigation	28a. Date (Mon.	of Injury th, Day Year)	ER/Outpatie	of 28c.	10	er: 4 Nursing	eath (Check only Home 5 Re 28d. Describe	sidence e how inju	ury occurr	ed	
Division Completed in the funeral Director. After the funeral Director. After the funeral prector. After the funeral Director. After the funeral Director. After the funeral Director. After the funeral Director.		4 Homicid	e deter	mined	buildi	ng, etc. (Speci	ny)	reet, factory, off		e, date and plac	City or T	own, Stat	te)		I Route Number,
To the Hospital within 24 hours a To the Funeral completely filled	_	(Check only one)  29b. Signature at	2 Medica	i Examiner	: On the ba	asis of examination of stated.	ation and/or in	vestigation, in r	ny or	pinion, death occ	urred at the time	e, date an	d place,	and due to	o the cause(s)  Day, Year)
		•	7	, W	9-	-		7	41	0854		1	14/	500	7
7		30. Name and ad				D	divo	Print) Risel	0e	rg 301	57. P	AUL	PL	Bc	Himore 220
State Registrar		31. Date filed (M	DR 2. 2		32. H	legistrar's Sign	B	Sport	2	/					

DHMH 16 Rev 6/95

			1 - For State Registrar  1. Decedent's Name (First, Middle, La		-	artment of I rtificate of		lental Hygien Reg. N	. 711111	1252
	Physici //vledic	al	•	rham		4h City Town	or Location of Death	April 20,	2004 Yeer	1:05 and
	Examir	er	Stella Maris Dul		У		aney Vall		Baltir	
	Funeral Director			ex 7. Age ☐ M 2 F	93 Yrs.	If Under 1 Year   Months   Days		8. Date of Birth (Month, Day, Yea 08/16/191	r) 9. Birth Cou	place (State or Foreign ntry) MD
	Aaryland I show	or	Usual Residence of Decedent  10a. State 10b. County  MD Balti	more	10c. City, Town or L	ocation Baltimore				10d. Inside City Limits 1 ☐ Yes 2 No
	with the Na or 28a-	Direct	10e. Street and Number 107 W. Elm Avenu	e		10f. Zip Code	21206	10g. 0	Citizen of What Cou	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23e or 28e-f show important: If Item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Exam har must be notified at Once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Vidowed 4 Divorced	12. Was Decedent I Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spo pan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whit	etc.
21215-0036	ithin 72 ho 19. 18n "natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	+) (Give	DO NOT use retire	during most of work ad)	ing 16b.	Kind of Business/In	•
and 21	t be filed w ntal Hygier ed other th	Be	8 17. Father's Name (First, Middle, Last Karl F.	0 Ballwanz	Mā	achine At	18. Mother's Name	e (First, Middle, Maide uzanna Ri	Refinar en Sumame) ttinger	<u>.Y</u>
Maryland	d 2 should th and Me t7 Is mark treumatic	70	19a. Informant's Name/Relationship ( Barbara M. Mille				t and Number or Rura	al Route Number, City	or Town, State, Zij	code)
Baltimore,	ages 1 an ant of Heal it: If Item 2 y or other		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State	20b. Place of Disp	osition (Name of nmatory or other pla	ace)		Location - City or T	
Baltin	permit. F Departme Importar any injur		21. Signature of Funeral Service Lice			2. Name and Addr harles L. 1501 Fast F	ess of Facility Stevens Fund	eral Home, Ir Baltimore M	rc.	-
85	Physician /Medical Examiner		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a	a consequence of):			or respiratory arrest,	1/35008	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of):					
.O. Box 68	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as it	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 manths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 \( \subseteq \text{Live birth} \) 4 \( \subseteq \text{Pregnant at} \) 9 \( \subseteq \text{Unknown} \)	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	су		23d. Date of deliv Month	ery Day Year
Δ.	uires that n signed b	by	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause gi	iven in Part I.	23e. Did tobacci	use contribute to t	
Vital Records,	The law requirate has been spage 2 should	Completed	Promotes.					24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
f Vital	ysician: is certifica director, p	To Be C	25. Was case referred to medical examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	ont 3□ DOA Ot	han	h (Check only one)		
Division of	ding After fune	Certification:	27. Manner of Death    Matural 5   Pending investigation   3   Suicide 6   Could not to determine   4   Homicide   Homicide   Homicide   Pending	98 Place of Ini	ury - At home, farm, s	M 1	ork? ]Yes 2 □No	28d. Describe how in 28f. Location (Street City or Town, Sta	and Number or Run	al Route Number,
ā	Hospital 4 hours Funeral ely filled	edical Cert	29a. Certifier  (Check only  2 Madical Exa	nysician: To the best	of my knowledge, dea			and due to the cause	(s) and manner as s	
	To the within 2 To the complete	Med	29b. Signature and title of certifier	and manner sta	2)	Z	nse number		Date signed (Month,	
	V		30. Name and address of person who EDDIE NAKHUDA	, M.D.	2300 DUI	, Print) ANEY VAL	LEY ROAL	TIMONIU	M MD 21	093
	St	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	Locales	•			

DHMH 17 Rev 1/200

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APRIL 20, 2004

DURHAM, MARGARET

			1 - State Registrar		epartment of Health and Certificate of Death	Mental Hygien	2001 10500
	Physic /Medi			dson		2. Date of Death April 20	3. Time of Death 5: 05 ρ м
	Examir	ner	4a. Facility Name (If not institution, give streether hospita	L Center	4b. City, Town, or Location of Dec		c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 1 D M Usual Residence of Decedent	2□F 52 Yr	Months Dave Hours Mir		51 Maryland
	the Maryland 28e-f show notified at	ctor	Maryland 10b. County NA	10c. City, Town of Bal	timore	ylar - dha	10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	th with 23e or	Funeral Directo	10e. Stedet and Number  2420 Seabut  11. Marital Status 12.	Y Rd. Apt. Was Decedent Ever in U.S.	10f. Zip Code  2/225		itizen of What Country?  USA  14. Race - American Indian,
5-0036	72 hours after dea "netural", or Items	þ	1 Never Married 2 Married	Armed Forces?  1 Yes 2 XNo If Yes, Give / Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 1 No Specify:	rto Rican, etc.)	Black, White, etc.
21215-0	within 72 h ene. then "netu	Completed	15. Decedent's Education (Specify only highest grade continuous Elementary/Secondary (0-12)		ecedent's Usual Occupation Give kind of work done during most of w fe. DO NOT use retired)	orking 16b. k	(ind of Business/Industry
Maryland 2	12 should be filed within and Mental Hygiene. 18 marked other then reumatic event, II.e.M.	To Be Co	17. Father's Name (First, Middle, Last) Thomas E. J	Davidson	18. Mother's Na	ame (First, Middle, Maider	Cey Dividen
•	and 2 sho lealth and N m 27 Is ma		19a. Informant's Name/Relationship (Type,	avidson 24	lailing Address (Street and Number or F	Rd. 45 Ba	ilto. Md. 21225
Baltimore	Page nent o ant: If ary or		20a. Method of Disposition  1 Magurial 2 □ Cremation 3 □ Remo  4 □ Donation 5 □ Other (Specify)	aamataa.	isposition (Name of crematory or other place)  15 Mem. Par K	Date 200. L	butus, Md.
Ba	permit. Departr Importe any inju		21. Signature of Funeral Service Licensee	Russ	22. Name and Address of Facility Joseph L. Rus 2222 W. North A	s Fuperal	1 Home . Md. 21216
	Fnysician /Medical		23a. Part T. Enter the disease, or complicating shock, or heart failure. List only one commendate Cause (Final disease or condition resulting in death)	Sub Mach sta	1 1/2 1	ic or respiratory arrest,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of).			
60,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
x 68760	leath certificate attending physi for use as the	/Medical	d	f yes, outcome of pregnancy			
P.O. Box	that the death ed by the atten detached for u	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P	w requires that been signed b should be det		Part II. Other significant conditions contribu	uting to death but not resulting in th	e underlying cause given in Part I.		use contribute to the cause of death?
		Completed by				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
of Vita	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hosp	1 Inpatient 2 ENOutpa	tient 3 DOA Other: 4 Nursing I	ath <i>(Check only one)</i> Home 5 ☐ Residence (	6 □Other (Specify)
Division	ttsnding Phy death. :tor: After thi :the funeral o	Certification;	1 Natural 5 Pending 2 Accident investigation	Ba. Date of Injury (Month, Day Year)  28b. Time Injury	y Wark? M 1 ☐ Yes 2 ☐ No	28d. Describe how injur	
Div	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer		4 Homicide determined	Be. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, State	
	o the Hos ithin 24 ho o the Fun ompletely	Medical	Check only 2 Medical Examiner:	On the basis of examination and/or and country stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	urred at the time, date and	and manner as stated. place, and due to the cause(s) e signed (Mgnth, Day, Year)
	- ≯ - 8		) Man	int		7 4	Pril 20 2004
	4		30. Name and address of person who completed the following of the second		P 17788  P 17788  Stanever 15t.	Baltimore	D 21225
	Sta Registr	_	ADD 2 2 2004	Beauce &	sparks.		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth Month Day **Physician** Lavinia Jane Dierdorff April 20, 2004 1:25 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Stella Maris Hospice If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Months 1□M 2₽F 494-32-3291 72 Director Jan. 15, 1932 Iowa Usuel Residence of Decedent e filad within 72 hours after death with the Maryland al Hygiana.
other than "naturel", or items 23a or 28e-f ehow 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ritems 23s or 28s-f show iner must be notited at Maryland Harford Abingdon 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 443 Crisfield Drive Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White ρ 3₺ Widowed 4 Divorced Year or Dates Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO,NOTuse, retired)
Medical Scientific Technical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) US Government Illustrator Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) 12 should be fire and Mantal Fire marked off Marjorie Frances Haliburton Paul Irwin Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Pegas 1 and 2 s mant of Haalth an 615 Coachman Way, Parkton, MD Paul R. Dierdorff/Son Depertment of Health Important: If Itam 27 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ò 4-23-04 Bel Air, MD any injury Bel Air Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death shock, or bear failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, MD 21009 Approximete Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical e. NON-SMALL CELL LUNG CANCER Examiner Due to (or as a consequence of) Be Completed by Physician/Medical Examiner Tha law raquires thet the death cartificata be executed tha buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): of Vital Records, P.O. Box 68760, Due to (or es e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient Medical Certification: To 1 Yes 2 No 3 DOA Director: Aftar this complataly fillad in by tha funaral 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 K Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e 1X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examine: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier J. 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State

**DHMH 16 Rev 6/95** 

Registrar

APR 2 2 2004

2004

20,

IANE DIERDORFF

Baltimore, Maryland 21215-0036

To the Hospitel or Attending Physicien: The law requires that the death carilicate be executed Division of Vital Records, P.O. Box 68760,

	1 - State Registrer			f Maryla		Certifica					Reg.	00	n la	1252
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Ţ	Joseph DiPi		Type Print)				Pauline Merti							
	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi									State, Zip	Code)			
	Joseph P. DiPietro Nephew 1512 Miller Road, Westminster, MD 2115 20a. Method of Disposition (Name of Disposition (													
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DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year) State Registrar

od cause of death (Item 23a) (Ty A TOTAK MF 32. Registrar's Signature

OCME

April 20, 2004

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2004 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 11: A M 4c. County of Death 4b. City, Town, or Location of Death allo Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number Days Mary 1 and 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Maryland Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number #2322 21234 U.S.A. 8810 Walther Blvd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 💢 No 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Hilgeman Eliza Montgomery Laurence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 205 Main Street, Box 335 Daughter Grant Town, W.V.26574 Dorothea Ensor White 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 4-24-2004 Baltimore Maryland Druid Ridge Cemetery eral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Sign Towson, Maryland 21204 1050 York Road Man 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Gangrene Due to (or as a consequence of): disease Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical **Examiner** 

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by the attending packed

signed by to

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this certificate has

After

To the Funeral Director:

funeral director.

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The law requires that the death certificate be executed

Division of Vital Records. P.O. Box 68760.

Examiner

by

Completed

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Certification: To

Medical

**Physician** /Medical

Examiner

**Funeral** 

Director

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Director

Funerai

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Completed

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death

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic avent. The second of the second

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician/Medlcai IF FFMALE 23b. Was decedent pregnant

betes

investigation

6 Could not be determined

2 ER/Outpatient

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed

C.

1 ☐ Yes 2 2 No 26. Place of Death (Check only one)

Care Center

25. Was case referred to medical examiner? 2 No 1 🗌 Yes

27. Manner of Death

1-Natural

2 Accident

3 Suicide

4 Homicide

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

3□ DOA

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

D 586 4

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State Registrar

Boule 32. Registrar's Sonature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 2 2 2004

Patient known as: Linda Dlane Force

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 [] [] 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Linda D. Ford 10:43 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local Dale of Birth (Month, Day, Year)

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

14 Onths Days Hours Min. 05-15-1966 Examiner 4c. County of Death Hospital of Baltimore Sinai 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 216-02-4140 1 □ M 2 ■ F 37 Director Yrs. Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked othar than "natural", or items 23a or 28a-f shov traumatic svant, the Medical Exatricat must be trutified at Director 1 ■Yes 2 □ No NA Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3912 Garrison Blvd 21215 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ■ Never Married 2 Married Baltimore, Maryland 21215-0036 Be Completed by 3 Widowed 4 Divorced Specify: natural', Black 15. Decedent's Education (Specify only highest grade completed) e filed within 72 has Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fii h and Mental H 7 Is markad otl George Ford Mary Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is i any injury or other traus 3912 Garrison Blvd. Baltimore, MD 21215 Ophelia Stanley/ Aunt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State Western Star Cemetery 4-26-04 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 636N.Gilmor St. balto, MDZ1217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia Preymoush's Carnel Physician week /Medical Due to (or as a consequence of): Examiner AIDS ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executions) Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hoxs after death.

To the Funarel Director: After this certificate has been signed by the attending physician and completely tilled in by the Innertal director, page 2 should be detached for use as the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably 4 Ohknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signatule and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) APR 2 2 2004

Keetika K-Padha, MD

2. Registrar's Signature

Sinai

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Spark

Hospital

April 20,2004

MAS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrar Certificate of Death Reg. No 2 0 0 L 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marie Frissyn 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🖫 🕏 374-10-8253 90 Yrs. Director 1913 November 11 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State rai', or items 23a or 28a-f show Examiner must be notified at 1 √Xes 2 No MD Anne Arundel Director Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 570 Bellerive Drive, Apt 203 21401 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 XX O Specify: white þ 3XXWidowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marked other than "natur 16b. Kind of Business/Industry College (1-4or 5+) Efementary/Secondary (0-12) Self Employed Restaurateur 10 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental Anton Peshl Teresa Ceman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 69 Department of Health a Important: if item 27 is any injury or other training. Ferdinand Frissyn / Son 127 Summer Village Drive, Annapolis MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 4/17/2004 XXSurial 2 Cremation 3 Removal from State Mt. Olivet Cemetery Detroit, <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) HService Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 East Fort Avenue, Baltimore MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ons 2017 00 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or): Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ed by the a detached f 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Yes 2 🗆 No 2 3 No 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After thi 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funaral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, APR 2 2 2004

30. Name and address of perso

(Check only one)

strugg ue 32. Pygistrar's Signature 1 Suc

who completed cause of death (Item 23a) (Type, Print)

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

5304

29d. Date signed (Month, Day, Year)

			1 - State Registrar	epartment of Health and Men Certificate of Death	Reg. No. 200	4 12528	
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) Rosa Farris	A	Date of Death Month April 10, 2004	2:05am M	
	Examir	ner	4a. Fecility Name (If not institution, give street and number) Prince Georges County Hosp.	4b. City, Town, or Location of Death Prince Georges	County Prince G		
	Funeral Director		5. Social Security Number 420–40–2746 6. Sex 1		Date of Birth 9. Bi	rthplace (State or Foreign country) AL	
Maryland e-f show	tor	Usuel Residence of Decedent  10a, State 10b, County 10c, City, Town of Prince Georges	r Location Largo		10d. Inside City Limits 1		
	3a or 28a	il Director	10e, Street and Number 603 Dwyer PL Largo MD 207	10f. Zip Code Largo	10g. Citizen of What C	•	
396	be filed within 72 hours after death with the Maryland and Hygiene. And Hygiene de thy filed that then "natural", or items 23e or 28e-f show of other than "natural", or items 23e or 28e-f show event. I're Medical Exertical must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica  1 □ Yes XX No Specify:	Yes or No- in, etc.) 14. Race - Am Black, Wh Specify:		
21215-0036	ihin 72 hou e. en "nature Madical E	Completed	15. Decedent's Education 16a. D. (Specify only highest grade completed) (C	scedent's Usual Occupation live kind of work done during most of working (e. DO NOT use retired)	16b. Kind of Business	s/Industry	
	be filed ital Hygi od othar	Be	11 0  17. Father's Name (First, Middle, Last) Thomas Jackson		rst, Middle, Maiden Surname) Fannie Unk.	Own Home	
Maryland	d 2 should th and Mer 27 Is marke 1 traumatic	2	19a. Informant's Name/Relationship (Type, Print)  19b. M	ailing Address (Street and Number or Rural Ro		Zip Code)	
Baltimore,	of Hea itam;		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  20c. Place of Disposition	5003 Dwyer PL., Largo sposition (Name of crematory or other place) d Cemetery  H177	200, Location - City o Birmingha		
Baltir	permit. Page Department ( Important: If any injury or 2000.		21. Signature of Funeral Service Licensee Victor Doda	22. Name and Address of Facility Charles L. Stevens Fu 1501 E. Fort Ave., Ba	neral Home, Inc		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Que to (or as a consequence of):		spiratory arrest,	Approximate Interval Between Onset and Death	
8760,	ate be executed sysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of de Month	olivery Day Year	
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?	
I Records,		Completed			autopsy prior to performed? performed?	utopsy findings available completion of cause of	
Vita V	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Ch.	eck only one)		
Division of Vital	ing Phys After this uneral dii	tion; To	1 ☐ Yes 2 ☑ No Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpa  27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpa  28a. Date of Injury (Month, Day Year) Inju	e of 28c. Injury at 28d. I	5 Residence 6 Other (Spe Describe how injury occurred	ecity)	
Divisi	al or Attending s after death. al Director: After ad in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide    Accident   Investigation	street, factory, office 28f. L	Location (Street and Number or R City or Town, State)	nd Number or Rural Route Number, a)	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, and dr investigation, in my opinion, death occurred at	fue to the cause(s) and manner a the time, date and place, and du	s stated. e to the cause(s)	
	Withi Com	M	29b. Signature and little of certifier	29c. License number	29d. Date signed (Mont	th, Dey, Year) -2004	
	U			pe, Print) 1 Drive, Cheverly MD 2	20785	,	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Soules .			

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			1_ For	State of Maryland	d / Depa		and Mental H	łygien	e	10500
			Registrar		Cer	uncale of Deali	2. Date of		. 2004	3. Time of Death
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Edith	Mae Graham			Month Apri	D	o, 2004	8:10 P <sup>M</sup>
7	Examin		4a. Facility Name (If not institution, give s Future Care Sar			4b. City, Town, or Location Baltimore		4	c. County of Death $N  /  \mathit{R}$	
	Funeral Director		5. Social Security Number 6. Sex 216-07-9743	м 2XF 7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year If Under Months Days Hours	Min. 8. Date of (Month, JAN ]	Birth Day, Year	9. Birth	place (State or Foreign intry)
	ryland how		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	th the Ma or 28a-f	ector	Maryland N/A			Baltimore	2	10a. C	itizen of What Cou	1 X Yes 2 No intry?
portition of syndical developments and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  By injury or other traumatic avent, the Medical Examinar must be notified and once.	Funeral Directo	1000 N. Gilmon			21217			USA		
	by	11. Maritat Status  1 Never Married 2 Married  3 💥 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispanic C f Yes, specify Cuban, Mexic 1 ☐ Yes 2 No Specif		No-	14. Race - Amer Black, White Specify:		
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	hould d Me mark matic	မှ	Charles W. Robe		19b. Mailin	ng Address (Street and Num	ary Chatm		or Town State Zi	n Code)
2	alth ar 27 in		Charles W. Graham,			Glenwood A			more. N	
ก ก	es 1 a of Hei f Item r othe		20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 3 ☐ Re	20b. Pl		sition (Name of natory or other place)	Date		Location - City or T	
	t. Pag tment tant: I		* 4 □ Donation 5 □ Other (Specify)	Metr		matory, Inc.		В	altimor	e, MD
ğ	Depar Impor any in		21. Signature of Funeral Service License	gorchik	Č	Name and Address of Each	ciety of	MD,	Inc.	- 01000
P	-		shock, or heart failure. List only on	a cause on each line	. Do not ent		s cardiac or respirator	y arrest,	more, M	Approximate Interval Between Onset and Death
£	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a control	ence of):	y discore				
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200	anding sath. or: Aft	atlo	1 Matural 5 Pending investigation	(MOITIII, Day real)	Injury	M 1 Yes 2	□No			
DIVISION	To the Hospital or Attanding Physician: within 24 hours after death, as a feet death or To the Funaral Director: After this certifical completely filled in by the funeral director; a	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,		eet, factory, office		n (Street a Town, Stai	and Number or Run te)	al Route Number,
	e Hospi 24 hou e Funer letely fill	edical	29a. Certifier 1 Cartifying Phys (Check only one) 2 Madical Examin	ician: To the best of my know ar: On the basis of examinati and manner stated.	ion and/or inv	vestigation, in my opinion, de	eath occurred at the tim	ne, date ar	nd place, and due t	o the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	10		29c. License number	( 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	29d. D	ate signed (Month,	Day, Year)
1			) Jegg			D17	ラ 5 T	AI	oril 21	, 2004
Ò	2		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	MOUNT R	oyal Are,	Ba	lto 2	1217
	Sta Registr		31. Date file of Month (Page Y Lat) 04	32 Ragistrar's Signat	ur Francisco					

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<b>Physic</b>	an	Decedent's Name (First, Middle, Last)	TOTALTEN DIOD CAL		2. Date of Death Month	Day Yeer	3. Time of Dea
/Medi		Rahy Girl Gardner		KUNEK	March	31 200	
Examir	ner	4a. Facility Name (If not institution, give street and Anne Arundel Medical (		4b. City, Town, or Location of Deat	th	4c. County of Dec	
		5. Social Security Numberunk 6. Sex	7. Age (In yrs. last birthday)	Annapolis  If Under 1 Year   If Under 24 Hrs	0.5.4.45.4	Anne A	
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hours after death with the Maryland tural', or flems 23s or 28s-1 show al Esamana mines for notified at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			Trad to its on the
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natifie	rec	10e. Street and Number		10f. Zip Code	100	Citizen of What C	
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E E	Funeral Director	11. Marital Status 12. Was	Decedent Ever in U.S. 13. Vid Forces?	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	USA 14. Race - Am	
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n 27 i er tre		O.C.M.E.		_	timore, MD	21201	
roth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr	20b. Place of Dispos	sition (Name of latory or other place)		. Location - City or	Town, State
ant: I		`4 □Donation 5 ☒ Other (Specify) in					
Important: If item 27 is any injury or other tra		21. Signature of August John Service Licensee ROTA D Wade	Alrector St.	Name and Address of Facility ate Anatomy Board Itimore, MD 2120	l 655 W. Ba	altimore	Street
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page 2	Completed				autopsy performed?	prior to death?	2 No
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the	icat	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
Ð Q	Certification:	4 Homicide determined 289. Pt.	ace of Injury - At home, farm, stree ilding, etc. <i>(Specify)</i>	et, ractory, office	28f. Location (Street City or Town, Sta	and Number or Ru ite)	ral Route Number,
<u>≅</u> ⊆	Medical C	29a. Certifier 1 Certifying Physician: To (Check only 2 XMedical Examiner: On the	the best of my knowledge, death	occurred at the time, date and place, stigation, in my opinion, death occur	and due to the cause	(s) and manner as	stated.
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o the Funeral Di	₹ -			29c. License number	1 29d F	ate signed (Month	Day Year)
To the Funeral Direc	Me	29b. Signature and tifle of certifier	$/I/\Lambda$				
To the Funeral Di		30. Name and address of person who completed \$\vec{\phi}\$	M	O.C.M.E.		ril 02, 2	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Stanley P. Gondzar 2004 APRIL 18 6:10 /Medical pm 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Berlin Nursing Home Berlin MD Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 362-24-7961 82 23,1921 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits : if item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Modical Examinar mast be notified at 1 ☐ Yes 2 ☐ No Worcester Director Berlin MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 799 PO Box 21811 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? TE Co. 11. Marital Status Armed Forces? US Coast
NOX'es 2 No Guard
If Yes, Give Guard
Year or Dates: WWII should be filed within 72 hours after nd Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 💥 No Specify White Specify: δ 3€3€Vidowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician 12 Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk. Unk. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 siment of Health an permit. Pages 1 and 2.1 Department of Health at Important: If item 27 is any injury or other tractors. Johanna Klemkowski / Friend P.O. Box 447, Ocean City MD 21843 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery April 22, 2004 Glen Burnie Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the arth line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Year 2 should be detached for Month Day 4☐Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by wasulare disease 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy page allure 1 ☐ Yes 2 No D or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Volume 15 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 2 [ No death. investigation 2 ☐ Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9 who completed cause of death (Item 23a) (Type, Print) Name and address of person FRUMICIL CUASTYT 16HUAY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State D Registrar APR 2 2 2004

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O.

DHMH 17 Rev 1/2001

STANLEY

GONDZAR,

			1 Starte Registrar	State of Marylan	-	artment of rtificate of			ene . No 2004	12532		
	Physici /Medio	al	1. Decedent's Name (First, Middle, La. Baby Bo	y Gaski	ns	4h City Tours	or Location of Death	Month	Day / Yeer 2004	3. Time of Death		
	Examir Funeral	C1	4a. Facility Name (If not institution, given by Med. S. Social Security Number 6. S.	ical Cente	2 R last birthday, Yrs.	301 Bal	T If Under 24 Hrs.	3. Date of Birth	Balmon (ear) 9. Birth	place (State or Foreign		
	Director		NA Usual Residence of Decedent  10a. State 10b. County	4   0	y, Town or L	ocation	59	rpnlli	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10d. Inside City Limits		
	with the Mar a or 28e-f e	Funeral Director	Md. NA  10e. Street and Number  2570 Hollins St	reet Apt 2	10f. Zip Code	223	10g	. Citizen of What Cou USA	Y☐Yes 2☐No intry?			
920	n 72 hours aftar death with the Maryland "netural", or Iteme 23a or 28e-f ehow palical Examination must be nutified at		11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Amed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spec ban, <b>M</b> exican, Puerto R o <i>Specify:</i>	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White, Specify: B1			
21215-0036		Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) Infant		(Give	dent's Usual Occi e kind of work done DO NOT use retir nfant	e during most of working	3	b. Kind of Business/Ir	dustry		
Maryland ?	nould ba filed d Mantal Hygis narkad other natic event, II	To Be C	17. Father's Name (First, Middle, Last) Dominic  19a. Informant's Name/Relationship (	Bank	4	inn Arthress (Stree	18. Mother's Name ( Tierra		Gask			
Baltimore, Ma	jas 1 and 2 st of Haalth and If Item 27 is n or other treun		Dominic Banks  20a. Method of Disposition  1	Father 20b. F	25° Place of Disp cometery, cre		ns Street A	pt. 2, B		Md. 21223 own, State		
Balti	parmit. Pag Dapartmant Importent: any Injury o		21. Signature of Funeral Service Licer  23a. Part1. Enter the disease, or com	Re	-	2. Name and Addi March F.	.H. East	1101 E.	North Ave	21202		
8760,	/Medical Examiner papers and pape	Ilcal Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· landia	uence of):  uence of):  uence of):	aclon	e Note naturi	fy		Onset and Death		
P.O. Box 68	Tha law raquiras that tha daath certifica ata has been signad by the attanding ph paga 2 should ba datached for usa as th		by Physician/Medi	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. It yes, outcome of pregna 1) Live birth 2 ☐ Feta 4☐ Pregnant at time of d 9☐ Unknown	death 3	⊒Ectopic pregnan ☐ Other (specify)	су		23d. Date of delive Month	Pery Day Year 17 200 Y
	w raquiras that is been signad by should ba data	eted by Ph	Part H. Other significant conditions of	contributing to death but not res	ulting in the o	underlying cause g	iven in Part I.	1 🗆 Yes	W.S.	the cause of death?  bably 4 Unknown  opsy findings available		
Vital Records,		e Completed	25. Was case referred to medical	1			26. Place of Death (		prior to co	ompletion of cause of 2□ No		
Division of Vi	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this cartific complately filled in by the funeral director.	Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. Inju	ury at 28 ork? □ Yes 2 □ Yo	3d. Describe how				
Divi	Ital or Atterns after dared Directo		4 Homicide determined	building, etc. (Specif	(y) 			City or Town,				
	To the Hospital within 24 hours a To the Funeral complataly filled	Medical	29a. Certifier 12 Certifying Pt (Check only 2 Medical Examone)  29b. Signature and title of certifier	nysician: To the best of my kno niner: On the basis of examina and manner stated.	ation and/or in	nvestigation, in my	opinion, death occurred	d at the time, date	and place, and due to Date signed (Month.	o the cause(s)		
	£ ₹ ₹ ¥		1 Jene	completed cause of death (Item	n 23a) (Type	D (	24740	A	mil 17	2004		
22	Sta	te	STEVEN W. (31. Date filed (Month, Day, Year)	32. Registrar's Signa	201	SF- 8a	rul Bac	e Bal	haugre, k	102142		
1	Regist	ar	ADD 9 9 2004	Acres 11	4	100 Vi						

DHMH 17 Rev 1/2001

				nd / Department of Health and  Certificate of Death	Mental Hygier	_
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last)  Frances R. Gree,  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	2. Date of Death Month	Day Year 3. Time of Death 2:30 M M
	Funeral Director		3737 Clarks Lane  5. Social Security Number 6. Sex 7. Age (In yrs. 126-18-1839 1 M 20 7 7 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min	8. Date of Birth	9. Birthplace (State or Foreign Country)
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or ltems 23e or 28e-f show event, I'm Modical Existing transitive rodified at	Funeral Director	10a. State 10b. County 10c. Ci  10b. Street and Number 10c. Ci  37 37 Clarks Cane	Baltimore  10f. Zip Code	10g. (	10d. Inside City Limits 1 ☐ Yes 2 ☐ No  Citizen of What Country?
9800	n 72 hours after death "naturel", or Items 23	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Oivorced  12. Was Decedent Ever in U Armed Forces?  1 Yes, 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puert  1 ☐ Yes 2 ☐ No Specify:		14. Race - American Indian, Black, White, etc.
d 21215-0036	filed within 72 h Hygiene. other then "natuent, the Matuent	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  7  17. Father's Name (First, Middle, Last)	16a. Decedent's Usual Occupation (Give kind of work done during most of work fife. DO NOT use retired)  Sccret Gr  18. Mother's Nan	nking 16b.	Kind of Business/Industry
Maryla	2 should and Men Is marke eumetic	ToB	Harry Rhett  19a. Informan Name/Relationship (Type, Print)  Donald W. Green   Son	19b. Mailing Address (Street and Number or Ru 328 Taylor Circle	Simn ral Route Number, City	nons
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr	20111	20a. Method of Disposition  1	Place of Disposition (Name of cometery, crematory or other place)  Selected Cemeters 4 - 2  22. Name and Address of Facility U	24-04 A	Location · City or Town, State  GLAG  Greene For Service
1	Inysician /Medical		23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	yourdeal Ort		Approximate Interval Between Onset and Death
	Examiner	ical Examiner	Sequentially list conditions,  Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the condition of the con	ypertension  Labeles  Juane of):  Lypercholesterole	ma	
.O. Box 6	that the death certificate be executed the by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Nor 9 ☐ Unknown  23c. If yes, outcome of pregnat 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
ords	requires een sign rould be	by	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I.	1 ☐ Yes	o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
	Physicien: The law this certificate has b al director, page 2 st	Be Completed	25 Was case referred to medical examiner?		24a. Was an autopsy performed?  1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Division of \	ng Phys fter this meral di	fication; To	27. Manner of Death  1  Natural 5 Pending 2  Accident investigation 3  Suicide 6 Could not be	EP/Outpatient 3 DOA Other: 4 Nursing Ho  28b. Time of Injury Work?  M 28c. Injury at Work?  1 Yes 2 No  2me, farm, street, factory, office	ome 5 Residence 28d. Describe how injute 28f. Location (Street a	
Dİ.	on the hospitel or attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Certification;	29a. Certifier 1 Certifying Physician: To the best of my kno	wledge, death occurred at the time, date and place, tion and/or investigation, in my opinion, death occur	City or Town, Stai	s) and manner as stated
	vithin 2-		29b. Signature and title of certifier  Mina 4 Miles We	29c. License number D46444		ate signed (Month, Day, Year)
	8		30. Name and address of person who completed cause of death (Item  NING F. Ever ett 2323 31. Date filed (Month, Day, Year)  92. Registrar's Signal	Orleans St Balti	nore MI	21224
	Sta Registra		APR 2 2 2004	And the second		

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar	•	artment of He ctificate of L		ntal Hygien	-2001.	12534
	Pĥysicia	an	1. Decedent's Name (First, Middle, L A. Mildred	Gobbel			2	Date of Death Month  AF'RIL	0ay Year 19,2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)	ter	4b. City, Town, or	Location of Death	4	c. County of Death	
	Funeral		Social Security Number     6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.   8 Hours   Min.	. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign intry)
	Director		250-09-1779 Usual Residence of Decedent	1□M <b>%</b> (XF) 8	5 Yrs.			0/20/19	918   S.	Carolina
	show	ō	10a. State 10b. County Maryland N	/ A	ty, Town or Lo Ba	cation 1timore				10d. Inside City Limits 1)X1Xes 2 ☐ No
	th the N or 28a-f	Director	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Cou	
	eath wi	Funeral D	732 Pacific	12. Was Decedent Ever in U	J.S. 13. V	Was Decedent of Hi	21211 spanic Origin? (Speci	fy Yes or No-	14. Race - Amer	
920	d within 72 hours after death with the Maryland Jione. I than "natural", or Itema 23a or 28a-f show The Medical Evaninal must be motified at	by	1 □ Never Married 2 □ Married  † ☑ Widowed 4 □ Divorced	Armed Forces? 1 □ Yes 2 ☑ ¾o If Yes, Give Year or Dates:	'	lf Yes, specify Cubai 1 ☐ Yes 24☐XNo	n, Mexican, Puerto Ri	can, etc.)	Black, White	white
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212	filed within I Hygiene. other then "	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Н	omemaker	18. Mother's Name (	First Middle Moid	In Own	Home
land	od a b	To Be	17. Father's Name (First, Middle, Last Daniel Mooneyh				Nancy Ca			
Maryland	a se se		19a. Informant's Name/Relationship Curtis Patrick			ng Address (Street a	and Number or Rural I		y or Town, State, Z	ip Code) 21047
	of Health of Health litam 27		20a. Method of Disposition 1x□xBuriai 2 □ Cremation 3	20b.	Place of Dispo cemetery, crea	osition (Name of matory or other place	Da	te 20c.	Location - City or 1	
Baltimore,	permit. Pages Department of HIMPortant: If its any injury or of ODES.		`4 □Donation 5 □ Other (Spec	eify) Gr	- P	and Address	rial 4/26	-	Columbi	
Ba	Depar Impor		ham A.	upertu		Burgee-H 3631 Fal	lenss-Sei L1s Road		eral Hom nore, MD	
		J	23a. Rant . Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final		th. Do not ent	ter the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)	a. SEPSIS  Due to (or as a conse						
h		er	Sequentially list conditions, fary, could be cause. Enter Underlying Cause (Disease or injury	b. Due to for as a consu		INFECTIO	N			
	ficate be executed physician and is the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. METASTATI  Due to (or as a conse		AL CELL	CANCER			
8760,	te be ey ysician ne buria	dical E		d						
9	death certifica attending ph d for use as th	Φ.	IF FEMALE:	23c. If yes, outcome of pregr	nancv				23d. Date of deli	verv
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown 3  Section 2 Fetal death 5 Other (specify)					Month Day Year		
4	es that igned b	by	Part II. Dther significant conditions		sulting in the u	indertying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Records,	w requires that been signed to should be det	leted	CONGESTIVE HEA					24a. Was an	24b. Were au	opsy findings available
I Re		Completed	CHRONIC RENAL	FAILURE				autopsy performed 1 Yes 2	? death?	ompletion of cause of
Vital	Phyaician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🌠 No	Hospital: 1 Kinpatient 2	☐ ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursing Hom		6 ☐Other (Spec	ifu)
of	ding Phys I. After this funeral di	h=	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c, Injury Wor	y at 28	3d. Describe how in		,,
Division	Attending r death.	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determine	be 200 Place of Injury . At	home, farm, st		Yes 2 No	3f. Location (Street City or Town, St	and Number or Ru	ral Route Number.
Ö	pital or ours afte aral Dira	Cert		Physicien: To the best of my kr		th accurred at the tim	ne date and place, ar			stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medicel Ex	eminer: On the basis of examir and manner stated.	nation and/or in	ivestigation, in my o	pinion, death occurred	d at the time, date a	and place, and due	to the cause(s)
<b>)</b>	To the within 2 To tha complex	Σ	29b. Signature and title of certifier	Homes	SAL	29c. Licens	e number 254		Date signed (Month	
	10		30. Name and address of person w	no completed cause of death (Ite	am 23a) (Type					
	St	ate	BOON F. I IM M. 31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature		N MARYLA	ND 2120	4	
.*	Regist		APR 2 2 2004	Beneva	6	facili				

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			1 - For State Registrar	State of M	aryland / [	Department of Ho Certificate of E	ealth and Men Death	ntal Hygien Reg. N		12535	
	Physici	an	1. Decedent's Name (First, Mid	dle, Last)	Le		2.1	Date of Death Month	Say Year	3. Time of Death	
1	/Medic Examir	cal	4a, Facility Name (If not institut)	on, give street, and number)	The state of the s	4b. City, Town, or	Location of Death	pr 10	2004 4c. County of Death	1810W M	
			5. Social Security Number	o Gent	Porpit	al Colu,	MDIA If Under 24 Hrs. 8	Date of Birth Month, Day, Yea	HOW	ard	
	Funeral Director		212.74.8154	1 M 2 F Q3 V Months Days Hours Min. (Moi						place (State or Foreign ntry) assachusetts	
	show		Usual Residence of Decedent  10a. State 10b. Coun	ty	10c. City, Town	n or Location				10d. Inside City Limits	
	Ba-f sh	ctor	Maryland	Howard	Colu	mb.J				1 ☐ Yes 2 No	
	3a or 2	Die	10e. Street and Number 5048 Amesbury [	21211					10g. Citizen of What Country? U.S.A.		
980	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Examinat De notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed Forces?	Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give  1 ☐ Yes 2 ☐ No If Yes, Give  1 ☐ Yes 2 ☐ No If Yes Obates:			Yes or No- n, etc.)	14. Race - Americ Black, White, Specify: With	etc.	
15-0	n 72 hours "natural", edical Exe	letec	(Specify only high	ent's Education est grade completed)	16a.	Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	tion uring most of working	16b.	Kind of Business/In	dustry home	
21215-0036	be filed within 72 ho ital Hygiene. id other than "natui event, the Medical	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+)		nemaker				
Maryland		Be	17. Father's Name (First, Middle Her	e, Last) Iry Clinton George			18. Mother's Name (Fir		en Sumame) beth Sharples	s	
ary	2 sh and and Is m	\$	19a. Informant's Name/Relation								
	1 an Heal em 2 ther		Mr William H. Carr	Griffith, Jr. Son	20b. Place of	Disposition (Name of	Date		1044 Location - City or To	own State	
Baltimore,	Page: nent o ant: If ary or			3 □Removal from State (Specify)	cemeter	y, crematory or other place inty Cremation Sen	04/40	*	-	, Maryland	
Balt	permit. Pag Department Importent: any injury c		21 Signature of Funeral Service	Lice ee Mo.	2535	22. Name and Address Slack F 3871 O	s of Facility Funeral Home, P Ild Columbia Pik	P.A. e Ellicott Cit	tv. MD 21043		
			23a. Part1. Enter the disease, shock, or heart failure. Li Igimediate Cause (Final	or complications that caused st only one cause of each li	the death. Do n					Approximate Interval Between Onset and Death	
1	Pnysician /Medical		disease or condition resulting in death)	a. Due of (p) as	a consequence of	1100					
1	Examiner		Sequentially list conditions,	b. ath	a consequence of	le con 2					
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rds, P	w requires that been signed t should be deta	þ	Part II. Other significant condi	tions contributing to death b	ut not resulting in	the underlying cause giver	in Part I.		use contribute to the	ne cause of death?	
of Vital Records,		Completed	pecep	Vende	es th	sombor		24a. Was an autopsy performed? 1 Yes 2 2 N	prior to cor death?	psy findings available impletion of cause of	
Vite	Physicien: 1 this certificat rat director, pa	o Be	25. Was case referred to medic examiner?  1 Yes 2 No	al Hospital: 1 ☐ Inpatie	ent 2 DER/Out	Othor	26. Place of Death (Ch		6 Other (Specif	4	
n of	g gg	on: T	27. Mann of Death	28a. Date of Inju	ry. 28b. T		at 28d. I	Describe how inju		,	
Division	Attendi	Certification:	2 Accident inves	tigation	ury - At home, far	M 1 ☐ Ye	es 2 □ No 28f. L	ocation (Street a	nd Number or Rura	l Route Number,	
Ö	Hospitel or Attending 14 hours after death. Funerel Director: After tely filled in by the fune		4 Homicide	building, et	c. (Specify)			City or Town, Stat	ө)		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledical	(Check only 2 Medics one)	ing Physician: To the best Il Examiner: On the basis of and manner sta	examination and	Vor investigation, in my opi	nion, death occurred at	the time, date an	nd place, and due to	the cause(s)	
)	will will	Σ	29b. Signature and title of certif	likhnic	W, 1	4D D -	50184	29d. Da	ate signed (Month, I	2004	
	0		30. Name and address of person	KAUKH	eath (Item 23a) (	Type, Print 9501 01	d Anna	pRd,	811. Ci,	My, MD	
	Sta Registr		APR 2 2 20	32. Registra	ar's Signature	Sparker	/	,	C		

State of Maryland / Department of Health and Mental Hygiene

			oldio or mary.	Certi	ficate of	f Death	F	Reg. No. 2	101.	2520
	Physician	Decedent's Name (First, Middle, Later John J. Haspert	·				2. Date of Dea Month	Day 7	Year ( D)	me-of Death) O
-	/Medical	4a Facility Name (If not institution, giv				4b. City, Town, or Lo	cation of Death	4c. County		290
	Examiner	Stella Maris at				Baltimore			N/A	
	Funeral Director		Sex 7. Age (In № 1 M 2 F 82	yrs. rast birtinday)	If Under 1 Yea Months Day		8. Date of Birth (Month, Day March 28		9. Birthplace (S Country) MD	tate or Foreign
	pug *	Usual Residence of Decedent  10a, State 10b, County	100	c. City, Town or Local	tion				10d. Insi	ide City Limits
	vith the Maryle or 28e-f sho be rectified at	MD N	VA	-		imore City		10a. Citizen of V		Yes 2□No
	uth with the Marylar 23a or 28e-f show unt be notified at ral Director	10e. Street and Number 1525 Hanover Stree			10f. Zip Code	21230			USA	
3h M 5-0020	should be filed within 72 hours after death with the Maryland not Mental Hygiene. I marked other than "natural", or items 23s or 28e-f show urretic event, fre Medical Examiner must be incitined at To Be Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2XXMarried  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1323(yes 2   No If Yes, Give Year or Dates: WA	ALLIN .	is Decadent of 'es, specify Cu IYes ≱Ç\N	f Hispanic Origin? (Spuban, Mexican, Puerto o <i>Specify:</i>	ecity Yes or No- Rican, etc.)	Specify		ın, 
	72 hg	15. Decedent's Ed (Specify only highest gra	ducetion ade completed)	16a. Deceder (Give kir.	nt's Usual Occ	upation ne during most of work red)	ing	16b. Kind of Bu	isiness/Industry	
121	ed within 72 hoygiene. Ner than "naturati, the Medical.	Elementary/Secondary (0-12)	College (1-4or 5+)	III. DO	Langsho			9	hipping	
d 2	be filed tal Hygie d other event, p	8 17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,			
an Jan	Mental H Mental H arked ott artic ever	Peter Haspert				Magde:	line R	ossbach		
BRENT	O	19a. Informant's Name/Relationship ( Frances Marion Ha				et and Number or Run Street, Balt			State, Zip Code)	
HA Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other ti once.	20a. Method of Disposition  >D② Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	Ob. Place of Disposit cemetery, crema Cedar Hill (	tory or other p		Date 1, 2004		City or Town, Sta re Marylar	
Balti	permit. Pages Department of Important: If It any Injury or o	21. Signature of Funeral Service Licer	nsee Victor P. I	Chai	rles L.	ress of Facility Stevens Funci t Avenue, Bal			21220	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	aplications that caused the	death. Do not enter	the mode of d	lying, such as cardiac	or respiratory ar	rest,		ximate al Between
	Physician /Medical	Immediate Cause (Final	one cause on each line.			striting			Onset	and Death
	Examiner	disease or condition resulting in death)	a	to (or as a conseque		9 400 00	- (3/5)	CISCA		
	icate be executed physician and s tha bunal-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury								
68760,	tificate being physicia as the bur	Cause (Disease or injury that initiated events resulting in death) Last	c. Due	to (or as a conseque	ence of):					
Вох	sath centitatanding for use a clan/M		d	· · · ·					<u> </u>	
	at tha death cer d by the attandir etached for use Physician/	Part II. Other significant conditions of	contributing to death but no	ot resulting in the und	erlying cause	given in Part I.	23b. Did 1	obacco use co	ntribute to the ce	use of death?
P.O.	d by the detach						1/2	Yes 2□ No	3 Probably	4 🗌 Unknown
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Medical Certification: To Be Completed by Physician/Medical Examir						24a. Was perfo	an autopsy rmed?	24b. Were auto available completio of death?	prior to in of cause
100 B	he law a has aga 2						101	res atino	1 ☐ Yes	
tal	en: T tifficat tor, pa	25. Was case referred to medical				26. Place of Deat	h (Check only o	nne)		
f Vi	hysicle nis cert I direct	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2□ ER/Outpatient	3LI DOM		ome 5 🗆 Resid	dence 6 ⊠Ōth	er (Specify) \	spice
o uo	nding Ph ith. : After th e funeral	27. Manner of Death 1. ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. In W	njury at Vork? □ Yes 2 □ No	28d. Describe h	now injury occur	red	S
Divis	lal or Attending P is after death. el Director: After t ed in by the funer: Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stree Specify)	et, factory, offic	СӨ	28f. Location (5 City or Tox	Street and Numb vn, State)	er or Rural Route	Number,
	To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	hysician: To the best of my miner: On the basis of exa and manner stated.	aminetion and/or inve	occurred at the stigation, in m	time, date and place, y opinion, death occur	and due to the red at the time,	cause(s) and ma date and place.	inner as stated. and due to the ca	iuse(s)
	To the comp	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date signe	d (Month, Day, Y	ear)
	. 4	▶ MY V	<b>b</b>		D5	10854		4/19	2004	
	10	30. Name and address of person who	completed cause of death	(Item 23a) (Type, Pr		301 KT ()	AUL PL.	2-11	14000	71202
	V Cô	31. Date filed (Month, Day, Year)	82. Registrar's	Signature	beng.	JUI 21.14	MUL PL.	Dan	unore o	KICUC
	State Registrar	ADD 2 2 2004	General	D M	oouts					

siciar	n	1. Decedent's Name	e (First, Middle ennis	, Last)			Hend	erson			2. Date of D Month APRII		f, 20	Year 004	3. Time of Death 12:52 P
edica mine		4a. Fecility Name (/	f not institution,	-				4b. Ci	, .	Location of Deat	h		c. County		1
al		MARYLAN  5. Social Security N		RAL 1			yrs. last birth		BALTIM der 1 Year	ORE CITY		lirth	NA		lace (State or Fore
		216-62-07 Usual Residence of	771		M 2□F	49		Month		Hours Min.			r)	Md.	place (State or Forei
		10a. State	10b. County			10c	City, Town	or Location						1	0d. Inside City Limi
otto	Director	Md.  10e. Street and Nur		AV			Ba	ltimor	Zip Code			100.0	itizen of V	What Cour	1 Yes 2 N
	בַּ	514 CAT		Str	eet			101.	2120	1			JSA	Wilat Cour	itty i
W Filhory	by Funeral	11. Marital Status  1 Never Marri 3 Widowed			2. Was Dece Armed Fo 1 Tes If Yes, Giv Year or Do	rces? 2 <b>X</b> ∏ No ⁄e	in U.S.	If Yes, s	cedent of Hispecify Cuba	ispanic Origin? (S an, Mexican, Puer Specity:	pecify Yes or No Rican, etc.)	10-		e - Americ ck, White,	etc.
4 Pot	ted		15. Decedent		ation	a185.	16a. [	Decedent's U	Isual Occup	ation		16b.	Kind of Bu	usiness/înc	
alam	Completed	Elementary/Seco	only highes andary (0-12)	grade	Collega (1	-4or 5+)		life. DO NO1	T use retired		rking				
		12th gr 17. Father's Name		Last)			O	ut Rea	ich Wo	rker 18. Mother's Na	ne (First, Midd			Serv	rices
0	To Be	Oliver			Hend	derso	n, Jr.			Inez			Feld	er	
ľ		19a. Informant's Na	ame/Relationsh	nip (Type	e, Print)		19b. l	Mailing Addre	ess (Street	and Number or R	ural Route Num	ber, City	or Town,	State, Zip	Code)
	1	Eleanor 20a. Method of Dis		lers	on Wi		b. Place of I	Disposition (A	Name of	Ave., B	eltimore Date	20c.	d. 2 Location	City or To	own, State
		1 ☐ Burial 2	Cremation 5 □ Other (Sp		moval from	State		, crematory`o nount (	_	4-20-	-04	Ba	ltimo	ore,	Md.
	-	21. Signature of Fu	ineral Service I	Licensee						on of Engiller				MA	27.202
		21. Signature of 1 c	Δ Δ		,			22. Name	and Addre	ss or racility	Bal	timo	re, l	Ma.	21202
		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition	he disease, or and failure. List of	complica	ations that co	ach line.	death. Do no	Marc	h F.H	. East	1101	E. N			
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			For State Registrar	State of Marylar		rtment of I tificate of			giene 10g. No.2011	12520
			Decedent's Name (First, Middle, Last)	)				2. Date of Dea		3. Time of Death
	Physici		William (;	awrence	Hadfi	eld		April	19 <sup>Day</sup> 2004	
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea		4c. County of De	
			17426 Wesley Char			Monktor			Baltimor	
	Funeral		Social Security Number 6. Sex	·	last birthday)	If Under 1 Year	If Under 24 Hrs		9 8	rthplece (State or Foreign
	Director		216-50-2986 15	X <sup>M 2□ F</sup> 54	Yrs.	Months Days	Hours Min	(Month, Day	, Year)	ountry) aryland
	Þ.		Usual Residence of Decedent					1000,00	, , , , , , , , , , , , , , , , , , , ,	ar yrana
	show	-	10a. State 10b. County	10c. Ci	ty, Town or Loc	ation				10d. Inside City Limits
	Ba-f	cto	Maryland Baltimo	ore Mo	nkton					1 ☐ Yes 2√ No
	or 2	Director	10e. Street and Number			10f. Zip Code			Og. Citizen of What C	ountry?
	ath w	ra	17426 Wesley Ch	rapel Road		211	11		USA 🐪	
	er de	Funerai		12. Was Decedent Ever in U Armed Forces?	J.S. 13. W	as Decedent of F Yes, specify Cub	Hispanic Origin? (S	specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
36	s afte	by F	1 Never Married 2 Married	1 □X es 2 □ No If Yes, Give	1	□Yes 2ŪXNo		, , , , ,	0	
8	hour	d be	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: Vie	1				100	Uhite
5	be filed within 72 hours after death with the Maryland ital hygiene. Id other than "natural", or items 23a or 28a-f show event, it a Medicul Examinal minat be notified at	Completed	15. Decedent's Educ (Specify only highest grade	e completed)	(Give k	ent's Usual Occup ind of work done O NOT use retire	during most of wa	rking	16b. Kind of Business	/Industry
12	withi ene. then	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)			ຫ les Man		C = 1 = =	
0	e filed within al Hygiene. other then '		17. Father's Name (First, Middle, Last)	4	Negro	Har Ja.		me (First, Middle, i	Sales	
an	Mental Mental arked o	o Be		dfield, Sr.			Evely			
Maryland 21215-0036	ges 1 and 2 should be it of Health and Mental if item 27 is marked or other treumatic ev	၉	19a. Informant's Name/Relationship (Ty)		19h Mailing	Address (Street			City or Town, State,	7-0-13
S	nd 2 :		Lynn Hadfield/							
ē,	es 1 and 2 of Health litem 27   r other tre	1	20a. Method of Disposition	20b. F	Place of Disposi	tion (Name of	1		Monkton, [ 20c. Location - City or	
Baltimore,	ages ant of t: If i		1 Burial 2 Tremation 3 R	lemoval from State	cemetery, crema	atory or other pla				
⋣	artme orten injur		* 4 □Donation 5 □Other (Specify)  21. Signature of Furleral Septice License	H1.	litop	Service Name and Addre	e Corp.	4/21/04	Towson,	Maryland
Ba	permit. Pages to Department of Himportent: If ite any injury or ot once.				R R	uck Tows	son Funer	al Home, son, Md.	Inc.	
	* 1		23a. Part1. Enter the disease, or compli	ications that caused the deal	h Do not enter	050 York	Rd. Tou	son, Md.	21204	
			shock, or heart failure. List only on Immediate Cause (Final	te cause on each line.		1	ig, sucii as cardiai	or respiratory arre	9St,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Lives 1		aus				3 years
	Examiner	- 1		Due to (or as a conseq	uence of):					2
	i i	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):	2				geden
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,					
Ć	n and ial-tra	Exa	that initiated events cresulting in death) Last	Due to (or as a conseq	uence of):					
8760,	Cate be executed physician and s the burial-transit	dical								
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6	onding puse as	n/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date of de	iverv
Box 6	death certiff e attending id for use as	ician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3 □E	ctopic pregnancy	,		23d. Date of de Month	ivery Day Year
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				State of Maryland / De		•	ene	
			1 - For State Registrar	C	ertificate of Death	Reg	1. No. 2004	1253
	Physici /Medic		1. Decedent's Name (First, Middle, La Isabelle Virg			2. Date of Death Month April 18	, <sup>Day</sup> 2004	3. Time of Death 12:05A M
	Examin		4e. Fecility Name (If not institution, giv		4b. City, Town, or Location of Dea	ath	4c. County of Death	
	*		Stella Maris Nur		Timonium		Baltimor	
	Funeral Director		214 10 12/3	Sex 7. Age (In yrs. last binthda M 2XXXF 84 Yrs	Months Davs Hours Mil	(Month Day )	(ear) 9. Birth Cou 1920 Mar	olace (State or Foreign ntry) yland
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location			10d. tnside City Limits
	he Mar 28a-f el	Director	Maryland Baltin		rimonium	100	California of Milhau Com	1 ☐ Yes 2/XNo
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f ehow valical Exacuter must be notified at	ai Dir	2300 Dulaney Val	Maris Nursing Home ley Road	10f. Zip Code 21093	100	g. Citizen of What Cou	USA
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 1 Armed Forces?	3. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- orto Rican, etc.)	14. Race - Ameri Btack, White,	
20	72 hours after natural', or Ite	by	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes <b>X</b> XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	white
3-003e	72 hou	Be Completed	15. Decedent's E (Specify only highest gro	ducation 16a. De	cedent's Usual Occupation	orkina 16	6b. Kind of Business/In	dustry
V	within lene. then	mple	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	ve kind of work done during most of w b. DO NOT use retired)		T., 1	
7 0	Hyg the nt,	Co	12 17. Father's Name (First, Middle, Last		nemaker	ame (First, Middle, Ma	In own hor	ne
yland	b la b	To Be	Lawrence Brandenl			Ellen Rees		
_	A D L L	-	19a. Informant's Name/Relationship (	Type, Print) 19b. Mi	ailing Address (Street and Number or I			Code)
Man.	and 2 Baith a n 27 la		William Hutchins	Sr. (Son) 8203	3 Cornwall Road F	Baltimore,	Maryland 2	21222
ore,	es 1 a of Hez fitem r othe		20a. Method of Disposition 1∑Burial 2 ☐ Cremation 3 ☐	Removal from State   cemetery, c	sposition (Name of rematory or other place)		Dc. Location - City or To	own, Stete
Baitimor	Pag Iment tent: I		* 4 ☐ Donation 5 ☐ Other (Special	Druid R	idge Cemetery 4/2		Pikesville,	
g	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Sign turn Funerat Savice Lice	ns le	22. Name and Address of Facility Burgee-Henss-Seit 3631 Falls Road	z Funeral	Home, Inc.	01011
n			23a. Part1. Enter the disease, or com	pications that caused the death. Do not die cause on each line.	enter the mode of dying, such as cardi	Daltimore, ac or respiratory arres	Maryland	Approximate
	Physician		tmmediate Cause (Finat	CEREBROVASCULAR		•		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequence of):	1100100111			
	Examiner		Sequentially list conditions	b				
d	pe is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (brias a nonsequence of):				
•	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c.  Due to (or as a consequence of):				
00,		7		d				
0	certificate nding phys use as the	ledic						
X O D	th cer tendir or use	an/N	tF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death	3 □Ectopic pregnancy		23d. Date of detive	ery Day Year
	he death the atten ched for u	by Physician/Medic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)		Worth	Day real
Ţ.	n requires that the de been signed by the should be detached	y Ph	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
coras,	quires an sign					1 🗆 Yes	2 No 3 Prot	pably 4 Tunknown
ပ္သ	2 8 2	Completed				24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
	The ate h	Com				performe	death?	
VII	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	User led.		eath (Check only one)	0.00	
0	Physi this c	7	1 ☐ Yes 2 ☑ No 27. Manger of Death	Hospital: 1 Inpatient 2 ER/Outpa		Home 5 ☐ Residen	ce 6 ☐Other (Specif	(y)
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JIVISION	or Attending after death. Director: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	OB Class of friend At home form		28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Pl (Check only 2 Madical Exa	nysician: To the best of my knowledge, deminer: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manner as s a and place, and due to	tated. o the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier	)	29c. License number		I. Date signed (Month,	
	(		> anyanso	ent MD	016619	1	tril ig.	2004
	6		30. Name and address of person who	completed cause of death (ttem 23a) (Typ	pe, Print)			
			CORAZON VERGARA-		DULANEY VALLEY ROA	D TIMONIU	M. MD 2109	3
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	/			

DHMH 17 Rev 1/2001

12:05 A.M.

ISABELLE HUTCHINS April 18, 2004

ORIGINAL

ARTHUR HAYNES Unknown 04-125 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-02527 State of Maryland / Department of Health and Mental Hygiene For State Registrar cmCertificate of Death Reg. No. 2 0 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Arthur HayNes 13 2004 2.03 Apri] /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and humber) 4b. City. Town, or Location of Death Examiner Baltimore
ar 1 Year | If Under 24 Hrs. | 8. Rear of 3200 Block Harwell Avenue Date of Birth (Month, Day, Year) If Under 1 Year Months Days Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Hours 1 M 2 F 219-80-8163 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f ehow the Medical Examiner must be notified at 1 Tes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 2 Items 23a 12. Was Becedent Ever in U.S. Armed Forces? 1 | Yes 2 (DNo It Yes, Give Year or Dates: Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural, or Ite 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 13/9 CK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction 1295 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hoggard 409999 Johnny 19b. Mailing Address (Street and Number or Rural Route Number, City 19a. Informant's Nam elationship 3022 heil tai 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baulliew Cemi Donda 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Wesley Shay: 5 Jr
2007 Eastern funeral Home 21. Signature of Funeral Service Licensee Pu A 23a. Part 1. Enter the glease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fautre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Strangulation and Suffocation **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year detached for in the past 12 months? 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No **Division of Vital** or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury — (Month, Day Year) 28d. Describe how injury occurred subject was strangled and suffaceted in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death After Certification: Found Found 4/13/04 5 Pending investigation 1 Natural 1 🗌 Yes death. after death 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Rear 3200 Block 3 Suicide 4 Homicide Baltimore, MD MNKNOWN Harwell Ave To the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. hi m.D April 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m.D LING LI 111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

APR 2 2 2004

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32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2 Data of Death Mogth **Physician** JARMAN /Medical 4b. City, Town, or Locetion of Deeth 4c. County of Death 4a Facility Nama (If not institution, giva street and numbar) Examiner BALTIMORE 5. Social Sacurity Number If Undar 24 Hrs. 7. Aga (In yrs. last birthday) If Undar 1 Yaar 8. Data of Birth (Month, Day, Yaar) Birthplace (State or Foreign Country) **Funeral** Days 217-20-0930 Usual Rasidence of Decedant 1 M 2□ F Yrs MARYLAND Director 10a. State 10c. City, Town or Locetion 10d. Insida Çify Limits BALTIMORE 1 Yas 2□No **Funeral Director** 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 21202 10 EASTL .S.A. Was Decadant Evar in U,S. Armed Forces? 1 Myes 2 □ No If Yes, Giva Yaar or Dates: 1915-46 13. Was Dacedent of Hispanic Origin? (Spacify Yas or No If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - Amarican Indian, Black, Whita, etc. 11. Marital Status 1 end 2 should be filed within 72 hours after Health and Mantal Hygiene. 2 Married 1 ☐ Yes 2 No þ 3 ☐ Widowad 4 ☐ Divorced JHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLORINE SCHUBERT HARRY WESLEY 19b. Mailing Address (Straat and Numbar or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nama/Ralationship (Type, Print) 18816 LIBERTY MILES GERMANTOWN MD 20878 ace of Disposition (Nama of Date 20c. Location - City or Town, State YNNE JARMAN of Health Saltimore, 20b. Place of Disposition (Nama of camatary, crematory or other place) 20a. Mathod of Disposition Pages 1 1 □ Burial 2 □ Cremation 3 □ Ramoval from State HANOVER, MD. ANATOMY GIFTS REG 4 Nonation 5 ☐ Othar (Specify) 21. Signature of Fundal Service Licenses 22. Nama and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Part1. Entar tha disaase com shock, or haart failure. List only Approximate Interval Batwaen Onset and Daath Physician Carhosis Immediata Cause (Final disaasa or condition rasulting in death) /Medical **Examiner** Due to (or as a consequence of) Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Due to (or es e consaquance of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consaguanca of) 23b. Did tobacco usa contributa to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Ware autopsy findings availabla prior to completion of causa of death? 24a. Was an autopsy performed? 2 1 No 1 Tes 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours aftar death. To the Funeral Director: After this certifica completaly filled in by tha funeral director; to Be 25. Was casa referred to madical examiner? 26. Placa of Death (Check only one) Hospital: Othar: 4 Nursing Home 5 Rasidance 6 Other (Specify) NOSpice Medicai Certification: To 1 ☐ Yas 2 ☐ No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Yaar) 28b. Time of 28c. Injury at Work? 28d. Dascriba how injury occurred 27. Mannar of Death 5 Panding investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, straet, factory, offica building, afc. (Spacify) 28f. Location (Street and Number or Rural Routa Numbar, City or Town, State) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiar V 30. Name and address of person who completed cause dath (Itam 23e) (Type, Print) berg

State Registrar 31. Date filad (Month, Day, APR 2 2

2004

72. Registrar's Signeture

George A. Kohlhupp 04-2062 AKG

Amend ITem#1,PERME,C832,6/8/04eg
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j.	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deat	⊥ March h	24, 2004 4c. County of	
			305 Joppa Road Ea	st Apt. 160	7	Towson			Raltim	ore County
	Funeral		5. Social Security Number UNK 6. Se	x 7. Age (In yrs	s. last birthda				1 9	D. Birthplace (State of Foreign Country) Unk
	Director			XIM 2□F 73	Yrs.		110010	NOV 2,	1930	dirk
	land		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or	Location				10d. Inside City Limits
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	r 28s	rec	10e. Street and Number			10f. Zip Code			0g. Citizen of Wh	at Country?
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36	s afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	unk	1 ☐ Yes 2 No		o moun, oto.,		White, etc.
Maryland 21215-0036	hours fural	pe pe	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	1 40- D					white
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B	be filed within 72 hours after death with the Marylan nat Hygiene. ad other then "natural", or items 23a or 28a-f ehow of other then "natural", or items 23a or 28a-f ehow event, the Medical Examinat must be notified at	BeC	17. Father's Name (First, Middle, Last)			unk	18. Mother's Nar	ne (First, Middle, i	Maiden Sumame)	unk
Jai	should be nd Mental marked o	To								din
a	and le me		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mai	ling Address (Street	and Number or Ru	ral Route Number	, City or Town, Sta	ate, Zip Code)
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J.	at the de by the a	hys	9 Unknown	9□ Unknown						
	w requires that s been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death but not re	sulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
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	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Med	29b. Signature and file of certifier	and manner stated.		29c. License			d. Date signed (M	
	F 3 F 8			In/IM				23		
			30. Name and address of person who co	impleted cause of death (Ite	m 23a) (Tvpa		M.E.		March 2	2004
			S.R. HOG	AN		111 Dor	n Street	. Baltim	ome Mam	yland 21201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature 4	Sports	/		- PRIL	THE LEVI
	Registra	ar	APR 2 2 2004	/all production	M	pyrones				

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Funeral Director		5. Social Security Number 235–44–6055		74 Yrs.	If Under 1 Yea   Months   Days		Min. 8. Date	of Birth oth, Day, X	£929	9. Birthpla Count West	ace <i>(Stat</i> e or Foreigi ry). Virginia
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Dallimore, permit. Pages 1 ar Department of Hea Importent: If item: eny injury or other onca.		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Fund al Silvice L	icensee	Metro Cre	ematory, <sup>2 Name and Add</sup> remation			rylar	Baltind, Inc		, MD
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or Attending Physicien: The law requires that the death certificate be executed the death.  Iter death.  Director: After this certificate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a color b.  Pregnant at time 9 Unknown  Is contributing to death but not be been been been been been been been	onsequence of): onsequence of)	Dectopic pregnand Other (specify) Int 3 DOA of 28c. Inju W M 1 reet, factory, office h occurred at the tovestigation, in my	26. Place ther: 4 \( \text{ Nur ury at ork?} \) Yes 2 \( \text{ Nur ury at ork?} \)	24a 1) of Death (Check sing Home 5) 28d. Des lo 28f. Loca City	Vas an autopsy performe.  Was an autopsy performe.  Yes 2 □ only one)  Residence cribe how tition (Street or Town, Street or town, Street or time, date	Month  20 No 3  24b. We private the private that and Number th	bute to the probal ere autops or to company?  (Specify)  or Rural in the probability of t	cause of death? bly 4 □Unknown sy findings available pletion of cause of □ No  Route Number, ted. he cause(s)
fending Physicien: The law requires that the death certificate be executed teath.  Iterations this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit.	edical Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a co	onsequence of): onsequence of)	Detopic pregnant Other (specify) Inderlying cause g  Int 3 DOA If 28c. Inju W M 1 C  reet, factory, office h occurred at the towestigation, in my 29c. Licen	26. Place then: 4 Nur viry at ork?	of Death (Check sing Home 5 28d. Des City place, and due in occurred at the	Mas an autopsy performed yes 2 □ only one) Residence cribe how the cause time, date	Month  200 use contrib  2 No 3  24b. We private the private of the	bute to the probable are autops or to compath?  Syes 2  (Specify)  or Rural I  oner as stated due to the state of the stat	cause of death?  bly 4 Unknown  sy findings available pletion of cause of  No  Route Number.  led.  he cause(s)
or Attending Physicien: The law requires that the death certificate be executed the death.  Iter death.  Director: After this certificate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burial-transit.	edical Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injuly that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a co	onsequence of): onsequence of)	Detopic pregnant Other (specify) Inderlying cause g  Int 3 DOA If 28c. Inju W M 1 C  reet, factory, office h occurred at the towestigation, in my 29c. Licen	26. Place ther: 4 Nur ury al ork? Yes 2 N	24a 1)2 of Death (Check sing Home 5)28d. Des lo 28f. Loca City  I place, and due in occurred at the	1 ☐ Yes  Was an autopsy performer yes 2 ☐ only one)  Residence cribe how tion (Street or Town, Street on the cause time, date 29d.  App.	Month  22 No 3  24b. We d? 24b. We d? No 12  e 6 Other injury occurred  at and Number thata)  Date signed (in)  The private of	bute to the probable or autops or to company?  (Specify)  or Rural I  where as stated due to the company of the	/ Year  cause of death?  bly 4 □Unknown  sy findings available pletion of cause of □ No  Route Number,  ted.  he cause(s)  ay, Year)
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	-	For State Registrar	State of Marylan		rtificate of			Reg. No.	2004	
		1. Decedent's Name (First, Middle, La	ast)				2. Date of De. Month	ath Day	Year	3. Time of Death
hysicia			Irene Lvovsk	сy			April	16, 2	2004	9:50P
/Medica Examine		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town,	or Location of Death	1	4c. C	County of Death	1
		12704 Veirs Mill	Road: Apt. 2		Rock	ville		Mo	ontgome	rv
ineral		5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Yea	r If Under 24 Hrs.	8. Date of Bir (Month, Da	th		place (State or Fore
ector		214-92-1184	1□M 2ŒF 59	Yrs.	Months Day	s Hours Min.	Dec. 1	9,194	44 R	ussia
	L	Usual Residence of Decedent								
74		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Lim
3	Į į	Maryland Montgom	ery	Roc	kville					1 X Yes 2 ☐
Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?
4		12704 Veirs Mill	Road			20853		IIni	ted Sta	ates
3	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.		f Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No		4. Race - Ame	ncan Indian,
i i	5	1 ☐ Never Married 2 🂢 Married	Armed Forces? 1 ☐ Yes 212 No If Yes, Give	I	7.7		o Hican, etc.)	1	Black, White	e, etc.
2	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give ** Year or Dates:		1☐Yes 2🖺N	lo Specify:			Specify: Wh	ite
alical Exa	ed	15. Decedent's E	Education	16a. Dece	dent's Usual Occ	supation		16b. Kin	d of Business/I	ndustry
	olet	(Specify only highest g		(Give	kind of work dor DO NOT use reti	ne during most of wor red)	rking			
9	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Sales			Hom	e Desig	n
event, the M	Š	17. Father's Name (First, Middle, Las	:t)		Bullo	18. Mother's Nar	ne (First, Middle,			,
•	Be	Abraham Soifer				Rosa So	ifor			
Tat:	ို	19a. Informant's Name/Relationship	(Tune Print)	19h Maili	ng Address (Stre	et and Number or Ru		er. City or	Town. State. Z	ip Code)
traumatic				1	1/200			_		
9		Steve Lvovsky/Son	20b. F	L&OL Place of Dispo	/ Kellar osition <i>(Name of</i>	t Drive;	Date		pation - City or	
or other tra		1 Burial 2 MCremation 3	THEINOVALITORI STATE		osition (Name of matory or other p					
any Injury or oth once.		* 4 □ Donation 5 □ Other (Spec			~	atory 04/	-			
o In		21. Signature of Funeral Service Lici	ensee	Ŝ	2 Name and Add imple Tr	dress of Facility Tibute Fun	eral and	Cre	mation	Center
ă		Muny S.	Derny	1	040 Rock	ville Pik	e; Rocki	7ille	, MD 20	
		23a. Part1. Enter the disease, or co- shock, or heart failure. List only	mplications that caused the deal y one cause on each line.	h. Do not en	ter the mode of d	lying, such as cardia	or respiratory a	rrest,		Approximate Interval Between
cian		Immediate Cause (Final disease or condition	_a Metastati							Onset and Death 4 Years
lical		resulting in death)	Due to (or as a consec		ot Cance	· L				4 Tears
iner										
	ē	Sequentially list conditions, if any, leading to thine finds cause. Enter Underlying Cause (Disease or injury	Due to for as a consec	juance off:						
ansir	ᆵ	Cause (Disease or injury that initiated events								
al-tr	Examiner	resulting in death) Last	Due to (or as a consec	quence of):						
s the burial-transit	cail		. d							
as the			0.							_
se as	Š	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn					2	3d. Date of deli	very
for use as	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a		□Ectopic pregna: □ Other (specify)			1	Month	Day Year
lached	ysle	1 ☐ Yes 2 🏋 No 9 ☐ Unknown	9□ Unknown		(-, / /					
detac	by Physician/Med	Part II. Other significant conditions	contributing to death but not res	sulting in the i	underlying cause	given in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
be de			•				10	Yes 2 🖸	XNo 3 □ Pr	obabiy 4 DUnkno
should	ted						-			
100	Completed						24a. Was	psy	prior to d	topsy findings avails completion of cause
1 (4	PO						1 ☐ Yes	ormed? 2∭ No	death?	2 🗆 No
page 2	Bec	25. Was case referred to medical				26. Place of De	ath (Check only	one)		
tor, page 2	ш	examiner? 1 □ Yes 2X No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	Other: 4 Nursing H	lome 5 🎇 Resi	dence 6	Other (Spec	cify)
director, page 2	.0	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. In	njury at Vork?	28d. Describe	how injury	occurred	
eral director, page 2	မ		, , , , , , , , , , , , , , , , , , , ,	mijury		☐Yes 2☐No				
funeral director, pag	မ	1 X Natural 5 ☐ Pending			treet, factory, offic	ce				ıral Route Number,
funeral director, pag	မ	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	286. Place of Injury - Act				City or To	wn, State)		
funeral director, pag	မ	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat		197						
funeral director, pag	Certification; To	1 Natural 5 Pending investigat 3 Suicide 6 Could not determine	building, etc. (Speci	owledge, dea	th occurred at the	e time, date and place	e, and due to the	cause(s)	and manner as	stated.
funeral director, pag	Certification; To	1 Natural 5 Pending investigat 5 Could not determine 29a. Certifier (Check only 2 Medicel Ex	building, etc. (Special Physicien: To the best of my knaminer: On the basis of examin	owledge, dea	th occurred at the	e time, date and place by opinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
funeral director, pag	မ	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  5 Pending investigat 6 Could not determine	building, etc. (Speci	owledge, dea	nvestigation, in m	e time, date and place by opinion, death occur ense number	e, and due to the urred at the time,	date and	and manner as place, and due e signed (Monti	to the cause(s)
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completely filled in by the funeral director, page 2	Certification; To	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  5 Pending investigat 6 Could not determine	Physicien: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, dea ation and/or ii m 23a) (Type	29c. Lice D2	ly opinion, death occi ense number	urred at the time,	29d. Date	place, and due e signed (Monti	h, Day, Year)

DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of	Maryla		irtment of H tificate of L		d Mental Hyg	giene Reg. No. 20	04	12545
	Physici /Medi		Decedent's Name (First, Middle, Last     William Long, Sr.	st)					2. Date of Dea Month	-	Yeer	3. Time of Death 11:40 am <sub>M</sub>
)	Examir		4a. Fecility Name (If not institution, give Washington Advent:				4b. City, Town, or Tacoma Pa			4c. County of	of Deeth	ery
E?	Funeral Director	-		ex CIM 2□F	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		(, Year) 926	9. Birthpla Counti	nce (State or Foreign y) PA
	Maryland B-f show	tor	Usuel Residence of Decedent  10a. State 10b. County  DC District of	of Columbi	-	ity, Town or Lo	cation				10	d. Inside City Limits
	h with the 23a or 28	ai Director	10e. Street and Number 1121 21st Street NE	Apt 102			10f. Zip Code 2000	2		10g. Citizen of W	hat Countr	y?
21215-0036	a within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23a or 28a-f show The Medical Evaninar must be notified at	Completed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed XX Divorced  15. Decedent's Ed	de completed)	ces? 2  No e tes:	16a. Deced	Vas Decedent of His Yes, specify Cubar  Yes XX No  ent's Usual Occupa kind of work done d NO NOT use retired)	specify:  tion uring most of w		14. Race Black Specify:		ack
d 212	F F F	0	Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle, Last)	College (1-	4or 5+)		Custo	odian	ame (First, Middle,	Nationa Maiden Surname		Callery
Maryland	Q 20 0	To B	William Long  19a. Informant's Name/Relationship (7)	Tvoe. Print)		19b Mailin	n Address (Street a		Thompso		State Zin (	Parta)
	ges 1 and 2 should it of Health and Mer if Item 27 is marks or other traumatic		William Long, Jr. /		205	1405	5 Hadwick La		B Essex MD	21221		
Baltimore,	Pages 1 ment of H ant: if Ite ury or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify	')	State N	ew Bethei	l Baptist O		1/23/200	20c. Location - 0	Macon,	
Balt	permit. Page Department of Important: if any injury or once.	Į į	21. Signature of Funeral Service Licen	see Victor	P. Doda	C	Name and Address parles L. S 01 Fast Fo	tevens Fl	neral Home, e, Baltimore	Inc. MD 21230		
8760,	Cate be executed by sician and physician and the burial-transit the burial-transit cate and the burial-transit cat	al Examiner	23a. Part1. Enter the disease, or comy shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Tay Leading to the Last of the Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c	ich line	quence of):		, such as card	ac or respiratory arr	est,	J	Approximate niterval Between Onset and Death
.O. Box 687	death certifi e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		th 2 Feta	al death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery	y yay Year
Δ.	signed be de	þ	Part II. Other significant conditions of	entributing to dea	ath but not res	sulting in the un	derlying cause give	n in Part I.		bacco use contrib es 2 □ No 3	oute to the	/
Vital Records,	The law ate has b page 2 st	Completed							24a. Was a autops perform 1 ☐ Yes 2	y pri ned? de	ere autops or to comp ath? Yes 2	y findings available pletion of cause of
ξ	Physician: T this certificat ral director, p	o Be	25. Was case referred to medical examiner?	Hospital:	patient 2	ER/Outpatient	Other		eath (Check only on			
ou of	ding After fune	$\Vdash$	27. Manner of Feath  1 Natural 5 Pending 2 Accident investigation	28a. The of (Month		28b. Time of Injury	28c. Injury Work	at	Home 5 Reside			
Division	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place o	of Injury - At h g, etc. (Speci	iome, farm, stre fy)	et, factory, office		28f. Location (St City or Town	reet and Number n, State)	or Rural F	Route Number,
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)	To t vith	Σ	29b. Signature and title of certifie	20	29	Sign	29c. License		60	9d. Date signed (	Month, Da	sy, Year)
	5		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type, F	chr	124.	60 BCC	ie M	00	20215
	Sta Registr		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ature	land					

Physician Department of Depart			For	State of Maryla	and / De	•	lealth and			0.01
Physician Research (Control of Case)  Formular and Fashly Nema (or of reliabilities) give see and nember (and planting of the series and nember)  Formular and Fashly Nema (or of reliabilities) give see and nember (and planting of the series and nember)  Formular and the series and nember (and planting of the series and nember)  Formular and the series and nember (and planting of the series and nember)  Formular and the series and nember (and planting of the series)  Formular and the series and nember (and planting of the series)  Formular and the series and nember (and planting of the series)  Formular and the series and nember (and planting of the series)  Formular and the series and nember (and planting of the series)  Formular and the series a					C	ertificate of	Death			
For the part of th			Dayliki I L	100 00				Month	Day	Year Ol On A.
Size Shows by the part and shows of the part of the pa			4a. Facility Name (If not institution, give	street and number)	1	4b. City, Town, o	or Location of Dea			
To Same Joseph To Joseph To Same Joseph To Joseph To Same Joseph To Jos	. Ladiii			& Marnl	and	Bal				
100   Size   100   County   100   Size   Si						Months Days			7 Year) 941	Birthplace (State or Foreign Country)     PA
The substitution of the property for the property of the pro	and			10c.	City, Town or	r Location				10d. Inside City Limits
The substitution of the property for the property of the pro	Maryli find	ğ	MD Anne Aru	ndel G	len Bu	rnie				1 XYes 2 No
The substitution of the property for the property of the pro	vith the or 28e	Direc					1		_	
The substitution of the property for the property of the pro	eath v	eral		12 Was Decedent Ever in	us. 1			Specify Yes or No-		
WILLIE Lonnain   Section	rs after d	by Fun	1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 🖸 No II Yes, Give				rto Rican, etc.)		ck, White, etc.
WILLIE Lonnain   Section	2 hour	ted	15. Decedent's Edu	cation	16a. De	ecedent's Usual Occup	pation		16b. Kind of B	usiness/Industry
WILLIE Lonnain   Section	e. An n	nple			life	e. DO NOT use retire	ad)	orking	Bevei	race
WILLIE Lonnain   Section	ygien ygien her th	Co	To Cabada Nama (Cab Asidalla Land)	5+		Supervisor		ana /Firek Adiddle		
18. Maling Address (Sired and Number of Paris Route Number (Payor Town State, 2go Code)  MYS. Emma Jane Lohman/viie 379 Phirme Rd. Glen Burnie MD 21061  20s. Manual Jane Lohman/viie 20s. Maling Address (Sired and Number of Paris Route Number of Route Number of Paris Route Number of Paris Route Number of Route Number		Be							maiden Surnan	ne)
Mrs. Emma Jane Lohman/virie 379 Phirms Rd. Glen Burnie MD 21061  20. Manead of Deposition of Solider (Specially)  21. Signature of Funeral Deposition (Single Control City of Town, State Stevensy)  22. Signature of Funeral Deposition (Single Control City of Town, State Stevensy)  23. Part Emma Jane Lohman/virie 370 Phirms Rd. Glen Burnie MD 21061  24. Signature of Funeral Deposition Funeral Home 1 Second Ave SW Glen Burnie MD 21061  25. Signature of Funeral Deposition (Single Control City of Town, State Stevensy)  26. Signature of Funeral Deposition (Single Control City of Town, State Stevensy)  27. Signature of Funeral Deposition (Single Control City of Town, State Stevensy)  28. Part Emma Jane Lohman M 21061  29. Signature and Stevensy (Single Control City of Town, State Stevensy)  29. Signature and State State Stevensy (Single Control City of Town, State Stevensy)  29. Signature and State St	should nd Me mark mark	P		pe, Print)	19b. M	ailing Address (Street			r, City or Town,	State, Zip Code)
Second Second Second Program   1   Second	17 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Mrs. Emma Jane Loh	man/wife	379	Phirne Rd	. Glen B	urnie MD	21061	
23. Part Carter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Chast railings.  And Carter the disease or complications and continuing to death and the continuing to death and the continuing to death and the continuing to death but not resulting in the underlying cause given in Part I.  23. Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence of):  Cause (client or security in death)  Due to (or as a consequence	of He of He r other			20t	p. Place of Di cemetery, o	sposition (Name of crematory or other pla	(ce) 4/1			
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Description (Medical disease)    Physician (Medical disease)	W. T. S. L.			5						Approximate
Due to (or as a consequence of):    Due to (or as a consequence of):	Physician		Immediate Cause (Final	119	,	Aort	ic Ax			Onset and Death
Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of):	/Medical					1		40	3. 1.	
FEMALE:   23b. Was decedent pregnant   1   1   1   1   1   1   1   1   1	Examiner		Sequentially list conditions.							
FEMALE:   23b. Was decedent pregnant   1   1   1   1   1   1   1   1   1	bei 1st	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):					
FEMALE:   23b. Was decedent pregnant   1   1   1   1   1   1   1   1   1	execui n and ial-trai	Exar	that initiated events	Due to (or as a cons	sequence of):				· · · · · · · · · · · · · · · · · · ·	
FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23d. Date of delivery   Month   Day   Year   23b. Was decedent pregnant in the past 12 months?   23b. Was decedent pregnant in the past 2 months?   23b. Was decedent pregnant in the past 2 months?   23b. Was decedent pregnant in the past 2 months?   23b. Was decedent pregnant in the past 2 months?   23b. Was decedent pregnant in the past 2 months?   23b. Was decedent pregnant in the past 2 months?   23b. Was decedent pregnant in the past 2 months?   23b. Was decedent pregnant in the past 2 months?   23b. Was decedent pregnant in the past 2 months?   23b. Was decedent pregnant in the past 2 months?   23b. Was decedent pregnant in the past 2 months?   23b. Was decedent pregnant in the past 2 months?   23b. Wa	te be ysicial		L,	J		~				
9 Unknown 9 Unkn	rtifica ing ph	Med	IE EEMALE:						1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes   2   No   3   Probably   4   Monown	ath ce	lan/l	23b. Was decedent pregnant	1☐Live birth 2☐F	etal death		у			•
25. Was case referred to medical examiner?  26. Place of Death (Check only onle)  27. Manger of Death  28. Date of Injury  28.	he de the a	yslc	1 ☐ Yes 2.⊠No		of death	5 ☐ Other (specify) _				
25. Was case referred to medical examiner?  26. Place of Death (Check only onle)  27. Manger of Death  28. Date of Injury  28.	that i	y Ph	Part II. Other significant conditions con	ntributing to death but not	resulting in th	e underlying cause gr	ven in Part I.	23e. Did to	bacco use cont	tribute to the cause of death?
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25. Was case referred to medical examiner?  26. Place of Death (Check only onle)  27. Manger of Death  28. Date of Injury  28.	law reas bee	plet								Were autopsy findings available
28a. Date of Injury - At home, Iarm, street, Jactory, office 28a. Could not be determined 28b. Place of Injury - At home, Iarm, street, Jactory, office 28c. Certifier (Check only one) 29a. Certifier (Check only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrar's Signature		Som	1					perfor	megs?	death?
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and titly of certifier  29b. Signature and dates of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29d. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	5 # in s	ertifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A building, etc. (Sp.	t home, Jarm,	, street, lactory, office		28f. Location (S City or Tow	treet and Numb n, State)	per or Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  295. PACA St. Bultimore: MD 21201  State filed (Month, Day, Year)  32. Registrar's Signature	Hospite 24 hours Funerel stety filled		(Check only 2 Medical Exami	ner: On the basis of exam						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  295. PACA St. Bultimore: MD 21201  State filed (Month, Day, Year)  32. Registrar's Signature	Fo the within Fo the comple	Me		101		29c. Licens	se number	2	29d. Date signe	d (Month, Day, Year)
295. PACA St. Baltimore: MD 21201  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	- > - 0		1 Michael	Cologn		Do	0588	43	4/17	104.
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	b						ND 21	201	-	1
	S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Si		1				

				State of Maryl					niana.	
			1 - For State Registrar	ĺ		ertificate of			Reg. No.	104 1254
	Dhusisi		1. Decedent's Name (First, Middle, L	ast)				2. Date of De Month		3. Time of Death
3	Physici /Medic		Paul	Lavix				April	16 20	04 3:54 PM
	Examin	er	4a. Facility Name (If not institution, g.		- ( / h.		or Location of Dea		4c. County of	
				Bayunen Med	yrs. last birthday		r If Under 24 Hrs	8. Date of Bir	th	N/A  9. Birthplace (State or Foreign
l.	Funeral Director		188-14-1056	1₽M 2□F 80	Yrs.	Months Days			ly, Year)	Country) Pennsylvania
	p.		Usual Residence of Decedent					Tidy II	1 1725	
	arylar show	-	10a. State 10b. County	100.	. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	the M	Director	Maryland Ba  10e. Street and Number	ltimore		10f. Zip Code	Du	ndalk	10g. Citizen of W	
	3a or	IDI		W i Ta			1222			States
	death ms 2	Funeral	1945 Denbury D:	12. Was Decedent Ever i	in U.S.   13		Hispanic Origin? (5 ban, Mexican, Puer	Specify Yes or No		- American Indian,
ထွ	or its	Ful	1 Never Married 2 Marned			1 ☐ Yes 2 No		to Rican, etc.)	Specify:	, White, etc.
00	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28e-f show aumatic avant, It a Medical Evaluation on the notified at	d by	3₺ Widowed 4 □ Divorced	Year or Dates:	WII					White
-5-	n 72	Completed	15. Decedent's l (Specify only highest g	rade completed)	16a. Dec (Giv lite.	edent's Usual Occu e kind of work done DO NOT use retir	upation e during most of wo ed)	orking	16b. Kind of Bus	iness/Industry
12	l withi	omp	Elementary/Secondary (0-12) 12 Years	College (1-4or 5+)		Brick Mas			Mason:	rv
פַ	e filed other	Be C	17. Father's Name (First, Middle, Las	it)				me (First, Middle,	, Maiden Sumame	
<u>a</u>	uld by Menta Irked	ToE	Andrew Lavix				Mat	ilda Cho	hutski	
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship				et and Number or A			
	1 and 2 Health Iem 27 I		Mrs. Paulette 1 20a. Method of Disposition			Pelczar A		Date Date	Maryland	21221 Dity or Town, State
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		1 ☐ Burial 2X Cremation 3	Hemoval Irom State		osition (Name of ematory or other pl				
	artme ortant injury		□ Donation 5 □ Other (Spec			22 Name and Add	Corp. 4/			, Maryland
Ba	permit. Departm Imports any inju		Man. (	· Canel	$\mathcal{L}$	Duda-Ruck	Funeral e Ave. I			
5.	(6)		23a. Part . Enter the disease, or co- shock, or heart failure. List onl	mplications that caused the c	death. Do not er					Approximate Interval Between
1 14	Physician		Immediate Cause (Final disease or condition	Cardiar	Archa	Shana (	Asystal	e)		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):	31-10-11-1				
Vi	CABITITIE		Sequentially list conditions, if any, leading to immediate	b. Hupox	i a					
	nsit	Examiner	Cause (Disease or injury	M	A . I	Fach	00			
,	te be executed ysician and te burial-transit	Ехаі	that initiated events resulting in death) Last	Due to (or as a con	sequence of):	1 300	20011			
	ite be iysicia ne bur	icai	•	d. Sepsis						
89	death certificate e attending phys id for use as the	Physician/Medi	IF FEMALE:							
Вох	ath ce ittend or usi	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	Fetal death 3	Ectopic pregnan	су		23d. Date Mont	of delivery h Day Year
O	he de / the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)				
ب	The law requires that the de ite has been signed by the page 2 should be detached	y Ph	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause g	iven in Part I.	23e. Did to	obacco use contri	oute to the cause of death?
Vital Records,	quires on sign uld be	ed by	Perghanal Vas	cular Disa	ca &			101	Yes 2□No 3	Probably 4 Unknown
ဝ	2 5 6	Completed	A cute on ch	innic Renal	Failu	re		24a. Was		ere autopsy findings available or to completion of cause of
ř	The ate has page	Com	Chrmic Obs	ructure Pul.	nen	DISTARC		perfo	rmed? de	ath?  Yes 221%
/ita	ding Physician: The I h. After this certificate ha funeral director, page	Be (	25. Was case referred to medical examiner?		7			ath (Check only o	one)	
0	Physi this c	T <sub>o</sub>	1 Yes 2 No		2 ER/Outpatie	HIL 3LI DOA			dence 6 Other	
uo	ding I h. After funer	tion	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Injury (Month, Day Yeel	r) 28b. Time Injury	We	ork? ☐Yes 2☐No	280. Describe r	how injury occurre	
Division of	Attender deat	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - A	At home, farm, s			28f. Location (5	Street and Number	or Rural Route Number,
á	al or	Certification:	4 Homicide determine	building, etc. (Sp	ecify)			City or Tox	wn, State)	
	To the Hospital or Attending Physician: To the Attending State deals after deals On the Funeral Director. After this certifics completely filled in by the funeral director, g	edical (	29a. Certifier 1 Certifying F	Physician: To the best of my aminer: On the basis of exam	knowledge, dea	th occurred at the i	time, date and place	e, and due to the	cause(s) and man	ner as stated.
	the hin 24 the F	Medi	one)	and manner stated.						
)	To To		29b. Signature and title of certifier	Anhon			- 000	-		(Month, Day, Year)
,	111		30. Name and address of person who	o completed cause of death i	(Item 23a) /Tunn				11/2-1	, , ,
4	111		Natalyn N	Hawk L	1940		Avenue	3.	Himm	e MD 21224
	Sta		31. Date filed (Month, Day, Year) APR 2 2 20	32. Registrar's Si	ignature 4	lan 1	,			
	Registr	ar	AFR & & ZU	04	1	popula	1			

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Re	g. No. 2	1251.8
	Physicia	an	1. Decedent's Name (First, Middle, Lest)	2. Dete of Death	Pay Year	3. Time of Beath
	/Medic Examin	al	Rached Lang  4a Facility Neme (If not institution, give street end number)  4b. City, Town, or Lo	ocation of Deeth	4c. County of Dec	9 A A S
	LAGITHI	Ŭ.	Stella Mosis S  Social Security Number 6 Say 7 7 Ape (In yrs lest hirthday) If Under 1 Year   If Under 24 Hrs.	more	0.0	Ab Jan (Chan a Fairle
	Funeral Director		5. Sociel Security Number 6. Sex 1 Months Days Hours Min.  7. Age (In yrs. lest birthdey) If Under 1 Year Months Days Hours Min.  1 Vrs. Worths Days Hours Min.	8. Date of Birth (Month, Dey,	-21 Bo	rthplace (State or Foreign July)
	irylend ihow		10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the Marylen r 28a-f show	ecto	MD  Battimore  106. Street end Number  107. Zip Code	10	g. Citizen of Whet C	
	th with	a Di	315 Winters Lane 21228		U.S.A.	
ec	17215-0020 within 72 hours effer death with the Marylend ene. than "natural", or items 23s or 28s-1 show than "natural" or items 13s or 28s-1 show he Madical Examiner must be incitting at	Completed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  2 □ Married  3 ■ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No  1 □ Y	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
4	21215-0020 d within 72 hours et giene. or than "natural", or or the Madical Exam	ed b	15. Decedent's Education 16a Decedent's Usual Occupation	king	6b. Kind of Busines	s/Industry
AC	/ithin 7	mpie	(Specify only highest grade completed)  [Give kind of work done during most of work life. DO NOT use retired)  [Give kind of work done during most of work life. DO NOT use retired)  [Secondary (0-12)   College (1-4or 5+)  [Secondary (0-12)   Secondary (0-12)		Dent.	Store
$\propto$	N DOL			ne (First, Middle, M	aiden Surname)	/
3	Vian Vida Mental Vikad c	To Be	Chance Mugrage Em	mA	Ram	
ANG	Baltimore, Maryland 2121 semit. Pages 1 end 2 should be filed within bepartment of Health end Mental Hygiene. mportant: If tem 27 is marked other than " iny injury or other traumatic event, tra Ma			4	City or Town, State, Sa H, 2	Zip Code)
C	S P P P P P P P P P P P P P P P P P P P		20a. Method of Disposition 20b. Place of Disposition (Name of		Oc. Location - City o	-
	Limo Page ment c		1 Burial 2 Defendation 3 Removal from State 4 Donation 5 Other (Specify)  Bayy, ew Cen	4-19-04	Balto.	MD. 21205
,	Baltimol permit. Pages Department of important: If it any injury or of	G	21. Signature of Fune al Service Licensee	115 5		era I Home
	-	-	23a. Part Linter the disease of complications that could the death. Do not enter the mode of dying, such as cardiac shoot, or heart failure. Lift only one cause on each line.	tern A		Approximate Interval Between
	Physician					Onset and Death
-	/Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)  a.			<u> </u>
		ner	Due to (or as a consequence of):			
	Vision of Vital Records, P.O. Box 68760, Attanding Physician: The law requires that the death certificate be executed ar death. ector: After this certificate hes been signed by the attending physician end by the funeral director, page 2 should be deteched for use es the buriel-trensit	edicai Examiner	Sequentially list conditions, aff any, leading to immediate			
	68760, ficete be ex physician ss the burie	caj E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evenits  Due to (or as a consequence of):  c			
	C 687	Medi	resulting in death) Last			
	Vital Records, P.O. Box stelan: The law requires thet the death cer certificate hes been signed by the attendin irector, page 2 should be deteched for use	Physician/M		22h Did tob	vecco uso contribui	ta to the cause of deeth?
	the de by the a teched (	hysi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Chronic Obstructor Long Discolo	1 7 Ye		Probably 4 Unknown
	15, P	by	Charle Officered Cong District	24a. Was an	autonsy 24h	. Were autopsy findings
	COrd	jetec		perform		available prior to completion of cause of death?
	Re lav	Completed by		+ ☐ Yes	2/2/No	1 ☐ Yes 2 ☐ No
W	f Vital Rec ysician: The law is certificate hes t director, page 2 s	Be	examiner?	th (Check only one		
1	Physical direction	n: To	27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at Model?	ome 5 ☐ Resider 28d. Describe hov		ecity) hospice
	Sion anding sath. or: Afte tun	atio	2 Accident investigation M 1 Yes 2 No			
	Division  or Attanding effer death.  Director: After d in by the fune	ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town,	eet and Number or I State)	Rural Route Number,
	To the Hospital or Attanding Phenithin 24 hours effer death. To the Funeral Director: After the completely filled in by the funeral	edicai Certification:	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the car rred at the time, da	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
_	To the within To the	Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mor	nth, Day, Year)
	m		D40854	- F	2/16/	<b>&gt;</b> 004
			30. Name end address of person who completed cause of death (Item 23a) (Type, Print)	more	21202	
	Sta		31. Dete filed (Month, Day, Year) 32. Registrer's Signature			
	Registr	ar	APR 2 2 2004 Source B sparks			

DHMH 16 Rev 6/95

Amend Item 23a per lease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ehman Year **Physician** Month 205 pm oseoh 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hopkins Bayview Center Medica n/a If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3/5/1918 Birthplace (State or Foreign Country) **Funeral** Days Hours 1<del>√</del> M 2□ F 86 218 01 5520 Director Maryland Usuel Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits "naturel", or Items 23a or 28e-f show the Medical Examiner roust be notified at MD Baltimore Rosedale 1 ☐ Yes 2 X No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 201 Potomac Avenue 21237 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 20 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. out: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Exxon Oil Industry Marine Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Lehman Ella Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lehman Wife 201 Potomac Avenue Rosedale Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State DCBurial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Importent: If any injury or once. Oaklawn Cemetery 4/19/2004 Baltimore MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Funeral Seprice Licensee 1211 Chesaco Avenue Rosedale Maryland 21237 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic Aspiration Pneumonia /Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy detached for Year Month Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peen Stroke 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 1 🗌 Yes 2 🗆 No Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 ☐ Yes 2 No 1 X Inpatient Other: 2 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Certification: within 24 hours after death. To the Funerel Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) catman, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern 31. Date fled (Month, Day, Year) APR 2 2 2004 32. Registrar's Signature State Registrar

			1 - For Stete Registrer	State	of Marylan		artment of H		d Mental Hy	giene Reg. No. 20	) 4	12550
ı	Physici	an	Decedent's Name (First, Middle, Virg.	*	L.	Moorh	And		2. Date of De Month April	_	Year	3. Time of Death
	/Medic Examin	cal	4a. Facility Name (If not institution,	give street and n		TIOOTII	4b. City, Town, or	Location of De		4c. County of	of Death	1:22 PM
		٠	Gilchrist Hospic		7 4 //	la as birebreta d	Towson  If Under 1 Year	If Under 24 h	Hrs O Date of Bio	Balt		
	Funeral Director		172 18 0405	.Sex 1XX M 2☐ F	7. Age (In yrs. 81	Yrs.	Months Days		firs. 8. Date of Birt 44onth, Da	1922	Pen	lace (State or Foreign htry) NSYOVANIA
	and **		Usual Residence of Decedent 10a, State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	e-feho	ctor	MD Balti	more		Rose	dale					1 □ Yes X No
	3a or 28	al Dire	10e. Street and Number 8113 Duval Avenu	ıe			10f. Zip Code	21237		10g. Citizen of W USA	hat Cour	ntry?
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importents if item 27 ie marked other then "neturel", or items 23e or 28e-f ehow enty injury or other treumetic event, i'm Medical Exam her must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	Armed F	cedent Ever in U. Forces? 2 No live WWII	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- uerto Rican, etc.)	14. Race Black Specify:	, White,	
0-0121	within 72 ho ene. then "netur he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed	(1-4or 5+)	16a. Deced (Give life. L Assem	dent's Usual Occupi kind of work done o DO NOT use retired bly	ation furing most of t }	working	16b. Kind of Bus		dustry
מוומ	id be filed ental Hygi ked other ic event, t	To Be Co	17. Father's Name (First, Middle, La William R. Moon	st)					Name (First, Middle, e Strong	Maiden Surname	))	
Mary	and 2 shou ealth and M n 27 ie mar ner treumet	-	19a. Informant's Name/Relationshi Edward Moorhead			19b. Mailir 811	ng Address <i>(Street a</i> 3 Duval <i>A</i>	and Number or Avenue	Rural Route Numbe	or, City or Town, S MD 21237	State, Zip	Code)
ווסומ,	Pages 1 aunent of Hezent: If item		20a. Method of Disposition  2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		n State Gar	Place of Dispo emetery, crem dens o	sition (Name of natory or other plac f Faith (	e) Cem. 4/	Date 23/04	20c. Location - 0	-	
Dailillo	permit. Departm Importe eny inju		21. Signature of Facer Service Li	censee	1	1	. Name and Addres	s of Facility	Cvach/Rose	edale Fu	nera land	1 Home 21237
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	Physician /Medical Examiner		disease or condition resulting in death)	aDue to	(or as a conseq	_	W.C.C.IX				-	gears
,007	cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liscotto of the that initiated events resulting in death) Last	c	o (or as a conseq							
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oida, r	quires that in signed b	by	Part II. Other significant condition	s contributing to	death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did to		oute to th	e cause of death?
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	10		30. Name and address of person w	no completed cau		23a) (Type,	Print) N. Cl	Carle	05 . 57. Bas	Sto. Md	2	1204
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	1	For State Registrar			Cei	rtifica	e of L	Death	I (C IVI	2. Date of Dea	eg. 14	°2004	1255
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ledica amine		4a. Facility Name (If not institution, g	give street and num	ber)		4b. City	Town, or	Location of				c. County of Deal	
		Casey House					ckvi		4 Neo			Montgo	
eral ctor		5. Social Security Number  484-40-0092  Usual Residence of Decedent	. Sex 7 1 □ M 21X1XF	7. Age (In yrs. 68	Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Feb. 13	Year I	936 Wasi	thplace (State or Fo.
Ħ	_	10a. State 10b. County			y, Town or Lo								10d. Inside City Li
any injury or other treumatic event, the Medical Executary trust be notified at 2000.	Funeral Director	MD Montgo	omery	G	aither		Code			1.	10a C	itizen of What Co	1 X Yes 2
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	To B	John Kingdon						Hel	len	Bready			
1		19a. Informant's Name/Relationship Edward Melsh/Son				-						or Town, State, 2	Zip Code) 20877
	1	20a. Method of Disposition		20b. F	_l Place of Dispo semetery, crei	sition (Na	me of	e)   Z	4/21	7°04		_ocation - City or	
		1 ☐ Burial 2 🗓 🖔 emation 3  1 ☐ Donation 5 ☐ Other (Spe			ltimor					,	Ва	ltimore,	, MD
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State Registrar

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31. Date filod (Month, Day, Year) APR 2 2 2004

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1, (1)

101 32. Registrar's Signatur O.C.M.E.

11 Penn Street, Baltimore, Maryland 21201

April 20, 2004

			1 - For State Registrar  1. Decedent's Name (First, Middle, Last)		ryland / Dep	artment of H	ealth and N	Mental Hygid	ene a. No. 200	به المحالية عند الم
	Physic /Medi Examir	cal		ghton		4b. City, Town, or	Location of Death	2. Date of Death Month April	Day Year 2004	3. Time of Death 12:15a M
	Funeral Director		Carroll Hospital  5. Social Security Number 6. Sex		(In yrs. last birthday Yrs.	Westmin If Under 1 Year Months Days	Ster If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Nov 13 1	Carrol1	
	within 72 hours after death with the Maryland ene. then "natural, or Itama 23a or 28a-f show ha Mudical Exemples frust be notified at	ector	Usual Residence of Decedent  10a. State 10b. County  Md Carroll		10c. City, Town or L Mancheste	er				10d. Inside City Limits 1 ☐ Yes 2 ♣ No
	th with the 23a or 2	Funeral Director	10e. Street and Number 2833 Park Avenu	e		10f. Zip Code 21102			g. Citizen of What Co USA	ountry?
920	urs after dea al', or Itama	by Funer	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give A Year or Dates;	ver in U.S. 13.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	te, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itama 23s or 28s-f show any injury or other traumatic svent, the Marical Examiner runt be northfload at ODGs.	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa e kind of work done d DO NOT use retired) lemaker	ition uring most of work	ing	domestic	/Industry
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, Mai	and 2 shealth and m 27 is n		19a. Informant's Name/Relationship (Ty) Patrick Naughton (		2833	ng Address (Street a Park Ave.	, Manches	ster, Md	21102	
Baltimore,	t. Pages 1 rtment of H rtant: if ite njury or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		Lake Vie	w Memoria	1 4-24-		ykesville	
Bal	Depar Impo		21. Signature of Funeral Service License  TugcHought	Herbert	- P	2. Name and Address	na: Svkesı 95	ville. Md	ral Home (	& Chapel
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	META	the death. Do not en	ter the mode of dying	, such as cardiac o	or respiratory arrest	t,	Approximate Interval Between Onset and Death
8/60,		Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last		consequence of):					
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DIVISION OF	anding Ph ath. or: After th he funeral		27. Manne√of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time o	Work?	at :	28d. Describe how		
	Hospital or Attanding 24 hours after death. Funaral Director: After tely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc.				City or Town, S	ŕ	
	To the Hospital or within 24 hours after to the Funeral Dircompletely filled in	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of er: On the basis of e and manner state	examination and/or in	n occurred at the time vestigation, in my opin	o, date and place, a nion, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated, to the cause(s)
	To the within 2 To tha Complet	Σ	29b. Signature and title of certifier	uter r	10	D35	398	29d,	Date signed (Month	Dey, Year)
	9		30. Name and address of person who con		555 Sc	Print) UTH CEN	ITER ST	REET W	DESTMINST	ER MD 2115
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signature					

DHMH 17 Rev 1/2001

ORIGINAL

		1 - State Registrar	Department of Health and In Certificate of Death	Reg. No2 0 0 4	1 - 0 0 1
Physic		1. Decedent's Name (First, Middle, Last)  Timotty Peltan		2. Date of Death Month Day Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give street and number) 944 Ocean Highway	4b. City, Town, or Location of Death Delmar		ath
Funeral Director		5. Social Security Number unk 6. Sex 1 M 2 F 7. Age (In yrs. last 1 M 2 F 3 G	birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. 8 (12/9/64	irthplace (State or Foreig Country) unk
r 28e-f show	or	10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
death with the Maryland ms 23e or 28e-f show rivast by notified at	I Director	10e. Street and Number  944 Ocean Highway Room 120	10f. Zip Code	10g. Citizen of What C	•
P # #	by Funeral	11. Marital Status Un K  1 Never Married 2 Married  3 Widowed 4 Divorced  1. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Never New Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1  Yes 2 No Specify:	pecify Yes or No- 14. Race - Am	nerican Indian, ite, etc.
	Completed I	754.51.54.55	Sa. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of Busines	
be file tal Hy doth	To Be Co	17. Father's Name (First, Middle, Last)	unk 18. Mother's Nam	e (First, Middle, Maiden Sumame)	unl
ite, Intalyiand		19a. Informant's Name/Relationship (Type, Print)  Wicomico Sheriffs Dept	9b. Mailing Address (Street and Number or Rul	al Route Number, City or Town, State,	Zip Code) unk
Dallimore, permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify) in state	of Disposition (Name of tery, crematory or other place)	Date 20c. Location - City o	r Town, State
Deartit. Departitions any injury inju		21. Sign, the of Funeral Sovice Licensee Ronal S. Wade, Director	State Anatomy Board Baltimore, MD 2120	1	Street
Pnysician /Medical		23a. Part1. Enter the disease, of complications that caused the death. D shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)	anging	or respiratory arrest,	Approximate Interval Between Onset and Death
certificate be executed XIII certificate be executed XIII certificate and XIII certificate as the burial-transit XIII certificate as th	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen			
death certific	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)	23d. Date of de Month	olivery Day Year
<u> </u>	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?
The law ate has b	Completed			24a. Was an autopsy performed?  1 Yes 2 No 1 Yes	utopsy findings available completion of cause of
Physician: The Physician: The Physician The Physician The Physician Physicia	To Be		Outpatient 3 DOA Other: 4 Nursing Ho	n <i>(Check only one)</i> me 5	ecify)
Jing After fune	Certification:	1 Natural 5 Pending (Month, Day Year) investigation (Month, Day Year)	. Time of Injury at Work?  Local Amount of Injury at Work?  1 □ Yes 2 □ No	Rope hanging	
Dire		4 Homicide determined building, etc. (Specify)	entin (enter	28f. Location (Street and Number or R City or Town, State) 994 Ocean HUY	
To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier  (Check only one)  1 Cartifying Physicien: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occur	red at the time, date and place, and du	e to the cause(s)
To with com	2	29b. Signature and title of certifier Drug	29c. License number	29d. Date signed (Mon	th, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a Chris Sryder b.o. 100 E	Carrollyt. Salisbu	1 MO 51801	
Sta Regista		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Sparks	•	

			1 - For State Registrar		laryland / Depa	artment rtificate			and M		Reg.	ne No20	04	12555
ı	Physici		1. Decedent's Name (First, Middle, Las Frederick Henry							2. Date of I	Death 19,	<sup>Day</sup> 2004	Year	3. Time of Death 9:55AM M
	/Medio Examir		4a. Facility Name (If not institution, give 3606 Lord Baltim	street and number)	)	N	1onkt		of Death			4c. County Ha	of Death	
	Funeral Director		5. Social Security Number 219–18–7438 6. Security Number 219–18–7438	7. Ag	ge (In yrs. last birthday) 80 Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	Jan. 9	Pay 19	24	9. Birthr Mary	place (State or Foreign http:// /Iand
	death with the Maryland	Ļ	10a. State 10b. County		10c. City, Town or Lo						-		1	0d. Inside City Limits
	the Maryla 28a-f shor	recto	MD Harfor	d	Monk	ton 10f. Zip	Code				100	Citizen of V	What Cour	1 ☐ Yes 2 ☐ No
	th with 23a or	ai Di	3606 Lord Baltimo	re Way			21111				log.	U.S.		ni y t
980	or its	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 [Yes 2 ] If Yes, Give Year or Dates:	No 943 – 1946	Was Decedi If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or I Rican, etc.)	No-		k, White,	
15-0	C 3	oletec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a, Dece	dent's Usual kind of worl DO NOT use	l Occupa k done di	tion uring most	of work	ing	16b	. Kind of Bu	siness/In	dustry
212	ad withing on the results of the res	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	eletyp					T	eleph	one ·	Company
Maryland 21215-0036	2 should be filed within and Mental Hygiene. is marked other than eumatic event, the M	To Be (	17. Father's Name (First, Middle, Last) Raymond J. Parr					Eli	zabe	th O.	Bur	khead		
Baltimore, Mar	ges 1 and of Health If item 27 or other tr		Mr. Glenn M. Parr	- Son	3606 20b. Place of Dispo cemetery, crer	Lord esition (Naminatory or oti	Balt ne of ther place	timor	e Wa	y Mor	kto 200	n, Ma	rylar City or To	nd 21111 own, State
İtim	t. Pa ntmen ntant:		' 4 ☐ Donation 5 ☐ Other (Specify		Parkwood									Maryland
B	Depa Impo sny ir		Raymond J. Parr  9a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town,  Mr. Glenn M. Parr – Son  3606 Lord Baltimore Way Monkton, Ma  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location											d 21214
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a the death. Do not entine.  SEESTIVE to a consequence of):  NACY AC	TEARY	- FA	HUU HSTA	RE	or respiratory	arrest,			Approximate Interval Between Onset and Death Smonths
8760,	cate be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of): a consequence of):									•
P.O. Box 6	e death certifi he attending hed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pre Other (spe						23d. Date Mor	e of delive	ry Day Year
	w requires that th been signed by t should be detach		Part II. Other significant conditions co CHRONU OBST		put not resulting in the un		USO GIVOR						ibute to th	e cause of death?
of Vital Records,		Completed by									s an opsy formed 2	? B	rior to con eath?	osy findings available inpletion of cause of
on of Vit	Phy this	lon: To Be	27. Manner of Leath	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	26. Place of Dea  1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H Date of Injury (Month, Day Year) 28b. Time of Injury Work?			sing Hor	11	idence	6 □Othe		)	
Division	Atten r deat ector: by the	Certification:	Accident investigation  Could not be determined	28e. Place of Inj building, et	ury - At home, farm, stre c. (Specify)	M eet, factory,		es 2 □ N		28f. Location City or To	(Street	and Numbe	or Rura	Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in I	edical	29a. Certifier Certifying Phy 2 Medical Exam	sician: To the best ner: On the basis of and manner sta	of my knowledge, death f examination and/or invated.	occurred a restigation, i	t the time	, date and nion, death	place, a	and due to the	cause , date a	(s) and mar and place, a	nner as stand	ated. the cause(s)
<b>.</b>	To ti To ti comp	×	29b. Signature and title of certifier		MD	29c.	License				29d. [	Date signed		,
	6		30. Name and addless of person who c		leath (Item 23a) (Type,			3501 7m	SAL	) M		4.19	204	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 2 200	32. Degistr	ar's Signature	Spa	els						<u> </u>	

			For State Registrer	State of Marylar		artment of H			iene g. No. 20 (	14 12556
	Ģ		Decedent's Name (First, Middle, Las	t)				2. Date of Deat	h	3. Time of Death
	Physici /Medic		William B. R	ush				April 2	1, Day 2004	2:55 A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of De	ath	4c. County of	Death
			Ruxton Health			Pikes				altimore
Ŀ	Funeral Director		213 20 3433		last birthday) 79 Yrs.	If Under 1 Year Months Days		in. 8. Date of Birth (Month, Day, SEP 13,	Year) 1924	Birthplace (State or Foreign Country) Maryland
	pue *		Usual Residence of Decedent  10a, State 10b, County	10c, Ci	ty. Town or Lo	ecation				10d. Inside City Limits
	e Maryle Ba-f sho	Director	Maryland Anne	Arundel		Arnold				1 ☐ Yes 2 🛣 No
	23a or 24		10e. Street and Number 340 Ternwing	Drive		10f. Zip Code	21012	11	og. Citizen of Wh. USA	at Country?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importents if Item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinational be notified at ance.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🖫 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 数Yes 2 No 194 If Yes, Give Year or Dates: 194	43-	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		American Indian, White, etc. White
21215-0036	thin 72 hore.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of v f)	vorking	16b. Kind of Busir	ŕ
2	led w lygier her th		47 5 No de Alexa (Fina Adidde / ea)	2	Ele	ectrician		(F) (AF) (#)		racting
Maryland	uld be fi Mental H Irkad otl	To Be	17. Father's Name (First, Middle, Last)  James W. Rush					<sub>lame (First, Middle, M</sub> en Albiker		
Man	nd 2 shouth and 1		19a. Informant's Name/Relationship (7 Cheryl Regensburg					Rural Route Number. e Apt. K		ate, Zip Code) re, MD 21209
Baltimore,	ages 1 and 2 nt of Health a nt: If Item 27 is y or other tra		20a. Method of Disposition  1 □ Burial 2 ☒Cremation 3 □	Romoval from State	cemetery, crei	sition (Name of matory or other place ematory,			20c. Location · Ci Baltimo	
3altin	permit. P Departme Importen any injuri 2059.		21. Signature of <u>Funeral Service Licen</u> Momow	seeQ.	Ci	ema end oddre:	30cTëty	of Maryla	and, Inc	
	402 8 0	$\vdash$	Thomas Gre	gor V				d Baltimo		Z1ZZ8 Approximate
	Fnysician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	a. Neuro ec				ac or respiratory arre	151,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	juence of):					
	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	<ul><li>b. Due to (or as a consect</li><li>c. Due to (or as a consect</li></ul>						
8760,	cate be e ohysiciar the burit	dicai		d.						
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	ıl death 3□	Ectopic pregnancy Other (specify)			23d. Date of Month	
<b>Q</b>	quires that n signed b	þ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause givi	en in Part I.			ute to the cause of death?
Vital Records,	The law requir ate has been sl page 2 should	Completed						24a. Was ar autopsy perform	prio ned?_ dea	re autopsy findings available if to completion of cause of th?
/ita	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					eath (Check only one		
of	ig Phys ter this neral di	ion: To	1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe ho		(Specify)
Division	ir.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, str (y)			28f. Location (Str City or Town	reet and Number ( , State)	or Rural Route Number,
	To the Hospitel or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death	n occurred at the tim vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manno	er as stated. If due to the cause(s)
	o the	Med	29b. Signature and title of certifier	and manifel stated.		29c. License	number	29	d. Date signed (A	Month, Day, Year)
	D - 2 - 2		> Kaun &	Balritt, M.	<b>&gt;</b> ,	DOC	5867	6 1	APTIL	21, 2004
	30		30 Name and address of person who	completed cause of death (Iter	n 23a) (Tyne	Print)	<u> </u>			*
•	Sta Registr		Karan L. Barbit- 31. Date filed (Month Par Year) APR 22 21	32. Kegistrar's Signa	ature	nell				,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #7&18 PER INF C831 5/05/05 JH
State of Maryland / Department of Health and Mental Hygiene

For State Amend Item 8 per FH,C830,04/30/04dhb Certificate of Death

Reg. No. 2 0 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 12:34 AM 21 2004 JAMES EDWARD ROGERS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimone Agnes Saint Health Care 8. Date of Birth 11/27/20 9. Birthplace (State or Foreign (Month, Day, Year) Country)
SEPT. 27, 1920 MD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 XM 2 ☐ F Director 83 214-18-3906 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other treumatic event, the Mudical Examiner must be nutified at 1 ☐ Yes 2 No Director NA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a WINDOR GARDEN LANE 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 \sum No 1944-185; Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: AFRICAN 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced 'natural', AMERICAN Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. WELDING Elementary/Secondary (0-12) College (1-4or 5+) 9th WELDER COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JAMES** ROGERS P MARY ROGERS CORA ROGERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RITA ROGERS (DAUGHTER) 2057 BENTALOU STREET BALTIMORE, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of himportent: If ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VET. CEM 4/26/04 any injury OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WYLIE FUNERAL HOME PA 1.00 638 N. GILMOR STREET BALTIMORE, MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** esti disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Corron years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit and resulting in death) Last Due to (or as a consequence of) 68760 the attending physicien Physician/Medical as the l Box IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 🗌 Yes 2 No of Vital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No r 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Director: After Division 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after 4 Homicide within 24 hours a To the Funerel C To the Hospitel Territying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04/21 104 SANJAY, VINJAMARAM. 17595 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANJAY 900 VINJAMARAM 31. Date filed (Month, Day, Year) APR 2 2 2004 32. Registrar's Signature State Registrar

			1 - For State	of Maryland / Dep	artment of Haalth and M	lental Hygier	ne 2001. 12550
			1 - State Registrar AMEND TTEM #20bo	Rc PER FH G890	rtificate of Death	Reg. I	
	Physici		Samuel	Robe	orts	Month [	Day Year 3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Death	APRIL 19,	2004 9:25a M
	LXaiiiii	101	1318 NORTH KENHILL AVEN	UE	BALTIMORE CITY		NA
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Yea 6-23-35	9. Birthplace (State or Foreign Country)
	Director		216-30-0875 M□ M 2□ F Usual Residence of Decedent	68 Yrs.		6-23-35	Md.
	/land		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Mar.	ctor	Md. NA	Balti	more		1 <b>K</b> Yes 2 ☐ No
	ith the	Oire	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Country?
	s 23a	rai	1318 Kenhill Ave.		21213		USA
36	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show the Modeal Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes,	s 2.∏OrNo	Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🎖 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	2 hou	ted	15. Decedent's Education	16a, Dece	dent's Usual Occupation	16b.	Kind of Business/Industry
2	ithin 7 ie. "n	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) College	(Give life.	kind of work done during most of worki DO NOT use retired)	ng	·
	led will led		11th grade	Wate	er Blaster		Cox Creek
auc	d be findal Head of	Be	17. Father's Name (First, Middle, Last) William H.	Roberts	18. Mother's Name Elizal	(First, Middle, Maid hoth	en Sumame) Mills
Maryland	should nd Me mark matic	<sup>L</sup>	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rura	_	
	alth a		Charity Roberts Wi:		B Kenhill Ave., Ba		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro  4 ☐ Donation 5 ☐ Other (Specify)	m State 20b. Place of Dispo	MORTAL PPARK	R	Location - City or Town, State ANDALLSTOWN, MD Dundalk, Md.
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	11000	2. Name and Address of Facility		more, Md. 21202
	201		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause o	t caused the death. Do not ent			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Hurosclendie Co	rlingered	Onset and Death
	/Medical Examiner		resulting in death)		0. 0300-00-0	7 SIE VIA	
	Zaminer	-	Sequentially list conditions b. Due	to (or as a consequence of):			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	o (or 25 2 55//350405//65 6/).			
oʻ	icate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last C. Due	o (or as a consequence of):			
38760,	ate be nysicia he bui	edicai	d				
•			IF FEMALE:				
P.O. Box	Attending Physicien: The law requires that the death certific rideath. rideath. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant 12c. If yes, o	gnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	s that ned b	by Ph	Part II. Other significant conditions contributing to	death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
g	w requires been sig should be					1 ☐ Yes	2 No 3 Probably 4 Unknown
Records,	The law re	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital	icien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?		26. Place of Death		10 10 10 20 110
<u>}</u>	Physic this co	0	1 X Yes 2 □ No Hospital: 1 [	Inpatient 2 ER/Outpatien			Other (Specify)
Z	ding Physicien: The n. After this certificate hi funeral director, page	ion:	1 Natural 5 Pending (M	e of Injury 28b. Time of Injury Injury	Work?	8d. Describe how inj	ury occurred
S	Attender death	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Pla	ce of Injury - At home, farm, str	M 1 Yes 2 No	8f Location (Street a	and Number or Rural Route Number,
2		Certification:	4 Homicide determined bui	iding, etc. (Specify)	set, raciory, ornos	City or Town, Sta	te)
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier  (Check only AF) Medicel Examiner: On the	he best of my knowledge, death	n occurred at the time, date and place, a yestigation, in my opinion, death occurre	nd due to the cause(	s) and manner as stated.
	To the h within 24 To the F complete	Medical	29b. Signature and tills of certifler	inner stated.	29c. License number		
	¥ ± 8		MAN	m	OCME	APR	ate signed (Month, Day, Year) IL , 2004
	N		5. K. HOGA	70	Print) Penn Street, Balti	more, Mar	yland 21201
0.00	Sta Registra	•	APR 2 2 2004	Registrar's Signature	Sports		

		1	For State Registrar	State o	of Marylar		artmen rtificate			and Me		giene Reg. No. 2	004	12560
Phys	siciar		Decedent's Name (First, Middle								2. Date of De Month	ath Day	Year	3. Time of Death
	edica	١.		ia Varg		ders	4 0	-		(5)	<u>April</u>		2004 unty of Death	3:15 P M
Exa	mine	r	4a. Facility Name (If not institution 524 Overda1		mber)		40. City,	rown, or	Ral +	timo:	ro		I/A	
Fune	ral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under 2	24 Hrs.	8. Date of Birt	th		place (State or Foreign
Direct		-	193-16-0793	1□M 2X1F	82	Yrs.	Months	Days	Hours	Min.	(Month, Da OCT 25	, 1921		"Virginia
and		- 1-	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
Manyl -f sho		2	Maryland N/A				Ва	1ti	more					1 XYes 2 ☐ No
h the		٠ د	10e. Street and Number				10f. Zip					10g. Citizer	of What Cou	ntry?
ith wit		2	524 Overda	Le Road					229				USA	
er des		Lamera	11. Marital Status	Armed Fo		I.S. 13.	Was Deced	lent of Hi cify Cuba	spanic Orig n, <b>Me</b> xican,	gin? (Spec , Puerto R	cify Yes or No lican, etc.)	- 14.	Race - Ameri Black, White,	
U36  urs after death with the Marylan el; or Items 23a or 28a-f show		Dy L	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Gi Year or D	Ve		1 ☐ Yes	2 <b>X</b> No	Specify:			Sp	ecity: Wh	nite
21215-0036  d within 72 hours after death with the Maryland giene. The four standard show the four than 1884 show the four tha		ie G	15. Decedent	's Education		16a. Dece	dent's Usua	al Occupa	ation	of workin	a	16b. Kind	of Business/In	dustry
ifthin 7		сошрієєє	Elementary/Secondary (0-12)		1-4or 5+)		kind of wor		)	0, 110,,,,,,	9		a	
V 255		3	17. Father's Name (First, Middle,	( ast)		Вос	kkee	per	18. Mother	r's Name	(First, Middle,		Compa	ny
E agla a		0 0	Andrew Varga								Mehli		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
re, Maryland s 1 and 2 should be file f Health and Mental Hy item 27 is marked oth			19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address	(Street a					own, State, Zip	Code)
C = 14 F		9	Sandra Michelle	Kreis/Dau							Jessu			
altimore, rmit. Pages 1 ar partment of Hea portant: If item	5		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 □Removal from	State	Place of Dispo cemetery, crea				Da		20c. Locat	ion - City or To	own, State
it. Page ritmen ritmen ritmen.		1	* 4 □ Donation 5 □ Other (S	oecify)	Met	tro Cre							imore	e, MD
Baltimore permit. Pages 1 Department of H Important: If ite	once		Thomas C.	Gregor	1	1 2	rema	red	h Sol	ciet k Ro	y of ad Ba	MD, I	Inc.	ID 21228
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dear								) L C • L	Approximate Interval Between
Physici	an		Immediate Cause (Final disease or condition		ASTR	DEN	TER	ITI	5					Onset and Death
/Medio			resulting in death)	Due to	(or as a consec	nuence of):				-	0 0 0	la ima		
LAGIIII		-	Sequentially list conditions, if any, leading to immediate	b. Due to	NETA.	STAT	1C	BR	EAS	1	CAN	CER	-	
uted		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		TYPER									
760, te be executed ysician and			resulting in death) Last	Due to	(or as a consec	quence of):								-
a sign	9 4	alcai		d	ORON	ARY	ART	KR	(Y 1	DISE	EASE			
. Box 68 death certificat e attending phy	20 00	Pnysician/med	IF FEMALE:	23c. If yes, ou	itcome of pregn	ancy						23d	. Date of deliv	arv.
death cert s attendin		Clar	23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ■ No	4□Preg	birth 2 ☐ Feta nant at time of c		⊒Ectopic pr ⊒ Other <i>(</i> s <i>p</i>					200	Month	Day Year
	1	y y	9 🗆 Unknown	9□ Unkr										
- Y +		ò	Part II. Other significant condition	ons contributing to d	leath but not res	sulting in the u	inderlying c	ause give	en in Part I.			obacco use Yes 2□N	/	he cause of death?
Vital Records, sician: The law requires t certificate has been signe		Completed									·			
The law	000	E C									24a. Was autor perfo	rmed.	prior to co death?	opsy findings available impletion of cause of
	9	au I	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only o	2 No	1 🗆 Yes	2 □ No
Of Vita Physician: this certifical director		0	examiner? 1 ☐ Yes 2 ▼ No	Hospital:	Inpatient 2	]ER/Outpatie	nt 3 DC	Othe			7		Other (Special	(y)
n of ng Physical dispersed of	9		27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury		8c. Injury Work			Bd. Describe I	now injury o	ccurred	
DIVISION O  Il or Attanding Ph after death. Director: After th		Icati	2 Accident investig	not be 200 Place	e of Injury - At h	lome farm et	M factor		Yes 2□N		Rf Location (	Street and N	umber or Rus	al Route Number,
Div A after t Direct to birect birect to birect		Certification:	4 Homicide determ	ined build	ling, etc. (Speci	fy)	iout, lactory	, 011100			City or Tov		5111001 01 7 IBN	
To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certified comploate, tilled in by the timeral director.			29a. Certifier 1 Certifyir (Check only 2 Medicel	g Physician: To the Examiner: On the t	e best of my kno	owledge, deat	h occurred	at the tim	ne, date and	d place, ar	nd due to the	cause(s) and	d manner as s	stated.
the H hin 24 the F	and :	Medical	one)	and mar	nner stated.	)			number					, ,
5 with 5 co	3	-	29b. Signature and title of certifie	1						11			2Z/0	
Í	07		30. Name and address of person	who completed cau	se of death (Ite	m <sup>1</sup> 23a) (Type.			/ / /	6		7/	4410	7
	1		700 GEII	E RD	SIE	200		1701	ISVIL	LLE	MI	) 2	1228	3
Rec	State	-	31. Date filed (Month, Day, Year)  APR 2 2	Se.	Registrar's Sign	ature	and a				•			

DHMH 17 Rev 1/2001

**ORIGINAL** 

		1	For State Registrar	State of Ma	ryland /		artment of H tificate of I			giene Reg. No. 20	104	12561
	Physici		1. Decedent's Name (First, Middle, Last) Joseph D	. Savalin	0				2. Date of Dea	Day	Year OGY	3. Time of Death
₩.	/Medic Examin Funeral		4a. Fecility Name (If not institution, give s	Hospita	(In yrs. last	<i>birthd</i> ay) Yrs.	4b. City, Town, or Rose Of If Under 1 Year Months Days	Location of De Cilc If Under 24 H Hours Mi	ath  15. 8. Date of Birt  (Month, Da)	h v. Year)	9. Birthpl	ace (Stete or Foreign try)
H	Director		Usuel Residence of Decedent						OCT 6,	1938		yland
	anylan sd et	5	10a. State 10b. County  Maryland Harfo	ord	10c. City, To	own or Lo	cation Fallsto	on.			10	0d. Inside City Limits 1 ☐ Yes 2 XNo
	a or 28a-1	Il Director	10e. Street and Number 2712 Fallston Ro				10f. Zip Code	21047		10g. Citizen of W	/hat Count	ry?
036	be filed within 72 hours after death with the Maryland tarthygiene. At Hygiene at the William Patural; or items 23a or 28a-f ehow event, the Medical Examiner must be notilised at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		i	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No- arto Rican, etc.)	14. Race Blace Specify	a - Am <i>e</i> nca k, White, e	
Maryland 21215-0036	within 72 ho ene. then "natur the Medical I	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed) College (1-4or 5-	+)	-	dent's Usual Occupi kind of work done o DO NOT use retired	ation during most of w	vorking	16b. Kind of Bu		
nd 2	be filed tal Hygid d other	Be Co	17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Middle,			320)
ryla	should be and Mental marked o	To I	Guinnero Savalino  19a. Informant's Name/Relationship (Ty.		1	9b Mailir	ng Address (Street		cy Cappol Rural Route Numbe		State Zin	Code)
	s 1 and 2 should f Health and Mer ftem 27 is marke other traumatic		Denise Oxendine/ni				2 Fallsto					
Baltimore,			20a. Method of Disposition  1  Burial 2  Cremation 3  R  4  Donation 5 Other (Specify)	emoval from State	ceme	otery, crer CO Cr	sition (Name of matory or other place ematory,	Inc. $4$		Baltin	ore,	
Balt	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Ligense	-		22 C	Name and Address remation	Society	y of Mary ad Baltin	land, In	ic. 2122	28
	Physician		Thomas Gree 23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that ceused	e.	o not ent		g, such as card		rest,	2 4 4 4	Approximate Interval Between Onset and Death
8760,	/Medical Examiner prize and prize transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a Due to (or as a	Hage consequence	Ce of):	disease	-				
.O. Box 687	ath certificate attending phys for use as the	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome  1 □ Live birth  4 □ Pregnant at  9 □ Unknown	2 ☐ Fetal de	ath 3[	□Ectopic pregnancy □ Other (specify)	,		23d. Date Mor	e of delive	ry Day Year
<u>α</u>	quires that the de n signed by the a uld be detached	by	Part II. Other significant conditions con	ntributing to death bu	it not resultin	ig in the u	nderlying cause giv	en in Part I.	23e. Did to	_/		e cause of death? ably 4 \( Unknown
I Records,		Completed								sy p rmed? d	rior to con leath?	osy findings available npletion of cause of 2 No
Vital	ician: certific rector,	Be	25. Was case referred to medical examiner?	lospital: 1 Inpatie	- 0UED	/O t = atio	Oth	er	eath (Check only o		(Ci4	
of	Attanding Physic death. sctor: After this by the funeral di	tlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injur (Month, Day		Outpatier b. Time o Injury	f 28c. Injur Wor	y at	3 Home 5 ☐ Resid	now injury occurr		)
Division	Dir afte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	iry - At home : (Specify)	, farm, st	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	er or Rura	Route Number,
	To the Hospital within 24 hours of To the Funeral I completely filled	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner sta	examination							
S.	To the within To the compl	Me	29b. Signature and title of certifier	<u>~</u>			29c. Licens			29d. Date signed		
	0	1		-Formey,	MD			1228		04 - 20		
	St Regist	ate rar	30. Name and address of person who could be seen as a seen and address of person who could be seen as a se	32 Regist	eath (Item 23	OF	erini)	gave "	Vive (	Roal in	ele,	HD. 1831

DHMH 17 Rev 1/2001

Savaline, Joseph

State of Maryland / Department of Health and Mental Hygiene  $200\,$  L 12562 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 20, 2004 William Arthur Spence 1:05a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long Green Center
5. Social Security Number 6. Se N/A If Under 1 Year II Under 24 His. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1XM 2□ F 212-56-5255 Director 52 ЛЛ 14, 1951 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Nadical Examiner must be notified at 17 Yes 2 ☐ No Director Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural, or Items 23s or i 2824 Harford Road 21218 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Arthur Spence, Sr. Hilda Sylvia Jeffries မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Z1Z1Z Data 20c. Location - City or Town, State Kyonya Spence Wright/daughter 5303 Midwood Avenue item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ö 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Metro Crematory, Inc. 4/20/04 4 ☐ Donation \_ 5 ☐ Other (Specify) Baltimore, MD 21. Signature Funery 5- 900 Licenses

Dawn M. McDonald Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE AIDS /Medical Due to (or as a consequence of): UNKNOWN Examiner NOOCARDITIS Sequentially list conditions, if any, leading to immuniate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law equires that the death certificate be executed MITRAL VALUE Due to (or as a consequence of): Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown E TOH Abuse 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan Intraveneus page 2 autopsy performed? (es 2 No 1□ Yes 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, r 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To o 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending 1 TYes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/20/04 D0059056 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALLIJA 6821 REISTERSTOWN Rd BALT MD 21215 DALJEET 31. Date filed (MAPR 2 2 2) 2004 Registrar's Signature State Registrar

Steven Steinman 04-02306 crn

**Funeral** 

Director

or 28a-f show

tems 23a

natural', or

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other thu any injury or other traumatic event, ITE SIRE

**Physician** 

/Medical

Examiner

Examiner must be notified at

the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Steven Steinman 2004 April 03 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 2307 Maryland Avenue, Apartment 10 Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Dec 22, 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 1111 k 1 X M 2 □ F 60 Usual Residence of Decedent 10a. State MD 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2307 Maryland Avenue #10 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. unk 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married unk 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation unk unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street baltimore, 21201 MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 💆 Other (Specify) in state 21. Signatur of Funeral Service Ronal d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Virector Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Monoi amotic CARDIOVASCULA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐⊌nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene 2 ER/Outpatient 1 Inpatient 3 DOA Medicai Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide

Hospital or Attending Physician: The law requires that the death certificate be executed burlal-transit attending physician detached for pe filled in by the funeral After death within 24 hours after death To the Funeral Director: the 2

> State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifie

HDRYDONOS 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 2 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RELL

south

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

April 04, 2004

		1 - For Uppend Item#	Zaru, rall	11,2/,	er m.	entificati	e of t	9eath		P	eg. No. 2 (	106	1256
		1. Decedent's Name (First, Middle	, Last)							2. Date of Dea		- V	3. Time of Death
Physici		Stanley Sha	innon							Month March 2	Day 5. 200	Year 4	11.45 7
/Medic Examin		4a. Facility Name (If not institution,	, give street and nu	mber)		4b. City,	Town, or	Location of	of Death	March 2	_,	y of Death	11:45 A
LAGITIII		301 South Smal	llwood Ct			D 3.							
Funeral		5. Social Security NumberUNK	6. Sex		s. last birthday	Balt If Under	1 Year	☐f Under		8. Date of Birth	1	9. Birth	place (State or Forei
Director			1⊠M 2□F	47	Yrs.	Months	Days	Hours	Min.	July 9,	, <i>Year)</i> 1956	Cou	intry) unk
		Usual Residence of Decedent				11				<u> </u>	1730	L	
Maryland f show		10a. State 10b. County		10c.	City, Town or I								10d. Inside City Limi
Mar Mar	tō	TID			Balt	imore							1) Yes 2 □ N
with the Marylar a or 28a-f show	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cou	intry?
Wil wil		301 S. Smallwo	ood Stree	t			21	223			US	2.4	
deeth ms 23	Funerai	11. Marital Status U	ink 12. Was Deci	edent Ever in	U.S. 13	. Was Deced			gin? (Spe	cify Yes or No-			ican Indian,
	ᆵ	1 Never Married 2 Marrie	Armed Fo ed 1 ☐ Yes		unk			n, Mexican	, Puerto	cify Yes or No- Rican, etc.)	Bla	ck, White	, etc.
hours after tural, or ite	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir Year or D	ve		1 ☐ Yes	No No	Specify:			Speci	fy: 1	olack
2 ho	Completed	15. Decedent	's Education		16a. Dec	edent's Usua	I Occupa	ation		1.	16b. Kind of E	Business/Ir	ndustry
n nat	pie	(Specify only highes			(Giv	e kind of wor DO NOT us	k done d e retired,	<i>luring</i> mosi )	t of worki	ng unk			u
d within jiene. r then *	E o	Elementary/Secondary (0-12) unk	College (1	1-40r 5+)									
De tiled htal Hygi ed other event, I	O	17. Father's Name (First, Middle, L				1	unk	18. Mothe	r's Name	(First, Middle, I	Maiden Sumai	me)	uı
\$ 5 5 0	00											,	
≾ ≥ ≅ ≅	ဥ	19a. Informant's Name/Relationsh	in (Type Print)		19h Mai	ling Address	/Street a	ad Numbe	r or Rum	l Route Number	City or Tour	State 7	a Codol
d 2 shi th and 7 is m traum		O.C.M.E.				. Penn							b Code)
them 2				20h	Place of Disp			eet		imore, N			Clat-
8 2 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from	State	cemetery, cri	ematory or of	her place	9)		419	20c. Location	- City or 1	own, State
ant:		' 4 □ Donation 5 📉 Other (Sp	ecity) in st	ate				i					
Department Page Important:		21. Signature of Eunoral Serve et Ronal of S	icensee	Precto	384 - 5	2. Name and	d Addres	s of Facilit	y	655 W.	D = 1 + 4		7.h
ded land		somewo	1////	106		altimo	re,	MD 2	21201	LOJJ W.	Daiti	ore :	street
Ite be executed xiscien and and purial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate auto. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (	(or as a conse		pertropi	hy						
ne death certificate the attending phys hed for use as the	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Fe iant at time of	tal death 3	□Ectopic pre						ite of deliv	ery Day Year
that the sed by detac	P	Part II. Other significant condition	as contributing to de	noth but not se	outting in the			n in Dard I		an Didush		12h 4- 4- 4	he cause of death?
og og	by	Diabetes Mellitus	no contributing to de	Sain Dot Hot 16	sauting in the	underlying ca	iuse give	nın ranı.					
been s	ted	Dialetes remus								1 1 18	s 2UNO	3 L PIO	oably 4 Unknow
as b	Pie l									24a. Was ar autops	24b.	Were auto	psy findings available impletion of cause of
sician: The law certificate has t irector, page 2 s	0									perform Yes 2	1ed?	death?	2 No
tor.	a	25. Was case referred to medical						26. Place	of Death	Check only one		7.55	2010
this certific	ToB	examiner? 1 XYes 2 ☐ No	Hospital:	npatient 2	] ER/Outpatie	nt 3[] DO.	Othe	e-				er /Specil	At scene
Viter		27. Manner of Death  1 XNatural 5 Pending 2 Accident investigs	28a. Date (Mont	of Injury th, Day Year)	28b. Tîrne Injury		c. Injury Work	at	2	8d. Describe ho			At Beene
volue nospitel of Attenda within 24 hours after death.  To the Funerel Director: A completely filled in by the t	Certification:	3 Suicide 6 Could no 4 Homicide determine	ned 28e. Place	of Injury - At ng, etc. (Spec	home, farm, s	treet, factory,	office		2	8f. Location (Str City or Town	eet and Numb , State)	er or Rura	d Route Number,
within 24 hours after	Medical C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the examiner: On the ba	best of my kr asis of examir ner stated.	nowledge, dea nation and/or i	th occurred a nvestigation,	it the time in my opi	e, date and inion, deat	d place, a h occurre	nd due to the ca d at the time, da	use(s) and ma ite and place,	anner as s and due to	tated. the cause(s)
e : e	S	29b. Signature and title of certifier	^			29c.	License	number		29	d. Date signe	d (Month,	Day, Year)
o the			/	1			O.C.	M.E.			March		
within To the comple		D/X / mkg	ALL										2001
within To the comple		1/ Corke	m	/									2001
within To the comple		30 Name and address of person w	mo completed caus	e of death (Ite	em 23a) (Type		ъ.			D 31.			
within within to the complete		30 Name and Address of person w 31. Date liled (Month, Day, Year)	INCKE	e of death (Ite			. Per		reet,	, Baltin			and 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month SOMMERVILLE **Physician** BESSIE 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NSgit Rehab If Under 24 Hrs. 8. If Under 1 Year 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Min. Months 1 □ M 2 X F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director more Mary and 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify: Specify: δ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/S econdary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Sumame) 18. 17. Father's Name (First, Middle, Last) Be 2 should be fit and Mental F 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (niece) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau ingto 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison 21. Signature of Funeral Service picensee Name and Address of Facility Home to ma Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that shock or heart failule. List only one cause on that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Due to (or as consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 12 No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an ongeitive autopsy performed? 2 No 1☐ Yes 2 No emen or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After **Division** 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director: / completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47804 and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

PLaza

Aberdeen

16 Abendeon

32. Registrar's Signature

MROWIEC

31. Date filed (Month, Day, Year)

			1 - State Amend Item 2 1. Decedent's Name (First, Middle, La		nd / Depa ) , 04 <i>(22)</i>	rtment of H	lealth and I Death	2. Date of Dea	ith	4 12566 3. Time of Death
	Physic /Medi Examii	cal	KETH B. SMIT 4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death	April	Day Ye 200	ear 03:15AM
	Funeral Director		5. Social Security Number 6. S		last birthday)_ Yrs.	Battle If Under 1 Year Months Days	M C PC If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Birthplace (State or Foreign
	Maryland f show	or	Usual Residence of Decedent  10a. State  10b. County  NA		ty, Town or Loc					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the Maryla a or 28e-f show be invitified at	Director	10e. Street and Number	D 445 H 4	ZITTOR.	10f. Zip Code			l0g. Citizen of Wha	
36	within 72 hours after death with the Maryland sne. than "natural", or items 23s or 28e-f show ta Medical Evantiner must be troiffled at	by Funeral	11. Marital Status  1. Marital Status	12. Was Decedent Ever in U. Armed Forces? 1  Yes 2 MNo If Yes, Give Year or Dates:	1 11	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black, V	A American Indian, White, etc. BLACK
Maryland 21215-0036	filed within 72 hours Hygiene. other than "natural", ent, the Medical Exe	Completed I	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	lucation	(Give k	ent's Usual Occupa ind of work done of ONOT use retired	ation furing most of work )	ing	16b. Kind of Busin	ess/Industry
yland 2	be filed Ital Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last, BERNARD SMITT					e (First, Middle, MCKAY	Maiden Sumame)	211010
	1 and 2 s Health ar tem 27 is		19a. Informant's Name/Relationship ( BERNARD SMT) 20a. Method of Disposition	1 20b. P	3224	Southe	REEN F	O. BA	City or Town, Sta	21244
Baltimore,	permit. Pages Department of Important: If is any injury or o		1 Surial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specification 2) 21. Signature of Funeral Service Licentary	MT	- XIDN	- Arbutu				np
	Physician		23a. Part1. Enter to disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	n. Do not enter	the mode of dying	ATL PIKE	BALTO.	MO 2122	Approximate Interval Between Onset and Death
N	/Medical Examiner	er	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Procun  Due to (or as a consequ  b. AIDS  Due to (or as a consequ	uence of):	.a				10 days
68760,	ficate be executed g physicien and is the burial-transit	edicai Examin	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	uence of):					
O. Box	w requires that the death certificate be executed been signed by the attending physicien and should be delached for use as the burial-transit	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	Ideath 3 🗆 🛭	ctopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Δ.	equires that een signed b ould be deta	ted by Pł	Parll. Other significant conditions of Renal Parl		ulting in the und	erlying cause give	n in Part I.	23e. Did tob		e to the cause of death?  Probably 4 Unknown
tal Reco	The law ate has b page 2 sl	e Compie	25. Was case referred to medical						y prior ned? death No 1 □ Y	a autopsy findings available to completion of cause of 1? Yes 2 \( \sum \text{No} \)
Division of Vital Records,	ng Phys fter this ineral di	ToB	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	26. Place of Death  4 □ Nursing Ho at ? es 2 □ No	me 5 🗆 Reside	a) nce 6 ⊡Other (S w injury occurred	Specify)
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	building, etc. (Specify	"	-		City or Town	, State)	Rural Route Number,
	the Hosp in 24 hou the Fune aptetely fi	ledicai	one) 2 Medical Exam	ysicien: To the best of my know iner: On the basis of examinati and manner stated.	wledge, death o ion and/or inve	occurred at the time stigation, in my opi	e, date and place, inion, death occurr	and due to the ca ed at the time, da	use(s) and manner ite and place, and c	as stated. due to the cause(s)
	with To 1	W	29b. Signature and title of certifier  NINA POL  30. Name and address of person who	1	23a) (Tuno D		5-00	0 1		21,2004
			NINA POLIAK	MD. SIN	ai	Hospi	tal .	4 130	altin	Love
	Sta Registr	te ar	31. Date filed (Mopth, Day, Year)	32. Registrar's Signat	ture					

			For State Registrar		Sta	te of Ma	ryland / [	Depa Cer	artment o <i>rtificate</i>	of Heal of Dea	lth and M ath	lental Hy	giene Reg. No	2004	12567
	-		Decedent's Name	(First, Midd								2. Date of De	ath		3. Time of Death
	Physicia /Medic		Willi	e	Н.		Syc	dnoi	c				15 Da	2004 Year	3:40pm M
	Examin		4a. Facility Name (If	not institutio	n, give street a	and number)					ation of Death		40	. County of Deat	1
			Joseph							altim				NA	
	Funeral Director		5. Social Security No 224–58–24		6. Sex 1 ☑ M 2		(In yrs. last birt	thday) Yrs.	If Under 1 Months D		Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da 2-3-4	ıy, Year	9. Birth Co. Md	nplace (State or Foreign untry)
	pug *	Ì	Usual Residence of 10a. State	Decedent 10b. County	,		10c. City, Town	n or Lo	cation						10d. Inside City Limits
	h the Maryland or 28a-1 show oppilied at	ò	Md.	•	NA		•		timore	•					Y☐Yes 2☐No
	the A	rect	10e. Street and Nun						10f. Zip Co				10g. C	itizen of What Co	untry?
	death with the Maryland ms 23a or 28a-1 show froust be notified at	Funeral Director	2412 E. I	Federa	l Stree	et.			2	1213			1	USA	
	ltems 2	Jera	11. Marital Status		12. Wa	s Decedent E	ver in U.S.	13.	Was Deceden	t of Hispan	nic Origin? (Spenican, Puerto	ecify Yes or No	)-	14. Race - Ame Black, White	
Maryland 21215-0036	after or Ite	by	1 Never Marri 3 ☐ Widowed		rried 1	Yes 2 N 'es, Give X ar or Dates:	lo		1 ☐ Yes 2		exican, rueno pecify:	ricati, etc.)			lack
0-10	72 hours "netural",	Completed	/Snec	15. Deceder	nt's Education	pleted)	16a.	Dece	dent's Usual (	Occupation	g most of work	ina	16b. l	Kind of Business/	ndustry
215	thin 7	nple	Elementary/Seco			llege (1-4or 5-		life.	DO NOT use	retired)	g moot or more	9	.,		
2	ygien yerth	S	11th grad				J	ani	torial		44 11- 4- 61	- /P* A 8*-J-H-		bacus Co	rp.
pu	be fill d of H	Be	17. Father's Name (	(First, Middle,	, Last)						Mothers Name Beatric	e (First, Middle	, Maide	n Sumame) Sydno	r
<u>Ş</u>	ould Men Jarke	ဥ	Unkn	(F) 1 1 1	11. Or D.	( - 4)	405	44-00-	- Add //				- City	or Town, State, Z	
Ma	is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 is marked other than "netur other treumatic event, the Mudical		19a. Informant's Na Sarelle			nn Daughte						Baltimo			213
	1 and Heali tem 2		20a. Method of Disp				20b. Place of	f Dispo	sition (Name	of		Date		ocation - City or	Town, State
Baltimore,	Page nent c		1 ☑ Burial 2 ☐ `4 ☐ Donation	5 Other (	Specify)	al from State		arı	natory or other nel Cen	n.	4-21	-04	Du	ndalk, M	d.
Ba	permit. Departrimporte any inju		21. Signature of Fu	neral Service	Ligensee		-		Name and A Narch E		,	1101 Ba	lti	more, Md rth Ave.	. 21202
	Physician /Medical Examiner	Examiner	23a. Mart. Enter the shock, or heat shock, or heat shock, or heat disease or condition resulting in death)  Sequentially list coin fany, leading to impause. Enter Unde Cause (Disease or that initiated events	nditions, nmediate injury	a	Due to (or as a	a consequence	of):							Interval Batyreen Onset and Death
68760,	rificate be executed ng physician and n as the burial-transit	edical	resulting in death) I	Last	d		a consequence	of):							
O. Box	The law requires that the death certifi te has been signed by the attending I age 2 should be detached for use as	by Physician/M	23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months? ☐ No	10	yes, outcome of Live birth Pregnant at Unknown	2 Fetal death		Ectopic preg					23d. Date of deli Month	very Day Year
rds, P	w requires tha been signed should be de		Part II. Dther signit	ficant condit	tions contributi	ng to death bu	ut not resulting in	n the u	nderlying cau	se given in	Part I.			use contribute to	the cause of death?  obably 4
al Records,		Completed										1 ☐ Yes	psy ormed?	24b Were au prior to death?	topsy findings available completion of cause of
Vital	ysiclen: Th is certificate director, pag	Be	25. Was case refer examiner?	red to medic	al Hospita	al:				Othor		h (Check only			thesina
of	Phys r this ral di	- To	1 Yes 2	th		1 🗀 inpatie		Itpatiei Time o		Injury at Work?		me 5 Resi		6 DOther (Specury occurred	102/102/10E
O	50 9 9	tion	1 ☐ Natural 2 ☐ Accident	5 Pend	ing tigation	a. Date of Injur (Month, Day	Year)	Injury	м	Work? 1 ☐ Yes			,	,	
Division	or Attending after death. Dirsctor: Afte in by the fune	Certification:	3 Suicide 4 Homicide	6 Could	1 201 20	e. Place of Inju building, etc	ury - At home, fa c. (Specify)	arm, st	reet, factory, o	office		28f. Location ( City or To			ral Route Number,
	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: Alf completely filled in by the fur	Medical Co	29a. Certifier (Check only one)		I Examiner: C		examination an		vestigation, in	my opinio	n, death occur		date ar	s) and manner as nd place, and due	to the cause(s)
		Σ	29b. Signature and	vitle of certif	/ Mill	MI	MI	D	29c. I	130	mber 1/2		29d. D	ate signed (Mont)	Day, Year)
	3		30. Name and add	pess of perso	n who complet	ed cause of de	eath (Item 23a)	(Туре.	Print	14/1	ond ?	AN D	3//	6, 14	1228
	Sta Regist		31. Date filed (Mor	2 2 20	04	32. Registra	ar's Signature	K	park					7	

		1 - State of Maryland / Dep	eartment of Health and I	Mental Hygie	20114 1256
Physici		Decedent's Name (First, Middle, Last)  ALBERT	SAUER	2. Date of Death Month	Day Year 3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street and number)  JOHNS HICKING BAJUEW MENCAL GUE	4b. City, Town, or Location of Death	Arril	4c. County of Death N/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday  220-05-3575 12xm 2 F 82 Yrs.  Usual Residence of Decedent	) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 28,	9. Birthplace (State or Foreign Country) Maryland
Maryland -f show	tor	10a. State 10b. County 10c. City, Town or L Maryland Baltimore	ocation Edgemere		10d. Inside City Limits 1 ☐ Yes 2% No
with the 3a or 28a	i Director	10e. Street and Number	10f. Zip Code 21219	10g.	Citizen of What Country? United States
DESIGNMOFE, MATYIBING Z1Z13-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	by Funerai	3109 River Drive Road   11. Marital Status   12. Was Decedent Ever in U.S.   13.   Armed Forces?   1	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Dallimore, Maryland Z1Z15-UU30 Permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiens.  In moortant: If item 27 is marked other than "natural; or any injury or other treumatic event, the Medical Exam- ance.	Completed	(Specify only highest grade completed) (Given Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation e kind of work done during most of work DO NOT use retired) Steelworker	king	o. Kind of Business/Industry
IZING IIII IIII IIII IIII IIII IIII IIII	To Be C	17. Father's Name (First, Middle, Last)  Bernard Sauer	18. Mother's Nam	e (First, Middle, Maid	
Mich y nd 2 shou tith and M 27 is mar r treumat		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rui 09 River Drive Roa	al Route Number, Ci	
more, Mis		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State  20b. Place of Disposementary, crematery, cremater	osition (Name of matory or other place)	Date 20c	Location - City or Town, State
permit. P Departm Importar any injur		21. Significant of Muneral Septite Licensee	.dge Mem. Park Cem 2. Name and Address of Facility Ouda-Ruck Funeral 922 Wise Ave. Dund	Home of Du	ındalk, Inc.
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of):			
requires that the death certificate be executed seems signed by the attending physician and hould be detached for use as the burial-transit	Physician/Medic		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
quires that n signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death?
The law ate has b page 2 s	Completed			24a. Was an autopsy performed 1 Yes 2 1	
th side	ation: To Be	25. Was case elerred to medical examiner?    Yes 2 No	nt 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 Residence 28d. Describe how in	6 □Other (Specify) Jury occurred
tel or Attending is after death. el Director: Afte ed in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
Hospi 4 hou Funer ely fill	edicai	29a. Certifier  (Crock only one)  1 Certifying Physician: To the best of my knowledge, deatt 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	s and manner as stated ind place, and due to the cause(s)
To the within 2 To the Complet	2	29b. Signature and title of certifier  MO	29c. License number  RES - OOL	1	Pate signed (Month, Day, Year)  PTL 17 2004
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Tec Ching, Juhn's Hopkin's BMC	RES - OOL Print) 4940 Eaten Av	erue , Bal	Hunne MD 21224
Stat Registra	e Ir	31. Date filed (Month, Pay, Year) APR 2 2004	Docksto		

10a. State

**Physician** 

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

## Copies Are Legible.

Sumuel

	-	Please Type or Print in Black Indelible Ink. Ensure All
Walter	Sumuel	**
RJD	For	State of Maryland / Department of Health and Me Unpend Item #23a-b&27 per me G831 5/12/04 tas strar
NOD	1 _ State	Unpend Item #23a-b82/ per me US31 5/12/04:tasto of Dooth
	Regis	strar Certificate of Death

Walter

ental Hygiene Reg. No.	2	Ω	0	1	ZX	jr wa
Reg. No.	6	U	U	4	2	$\mathbf{c}$

3. Time of Death

0116A.

2. Date of Death

April 18, 2004 Year

111 Penn Street, Baltimore, Maryland 21201

Exa

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

nation and a	lete	15. Decedent's Ed (Specify only highest gra	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)					
jiene. r than "nati the Medica	Complete	Elementary/Secondary (0-12)	Coilege (1-4or 5+) 1 Year	Truck Driver				
Hyg other	Be C	17. Father's Name (First, Middle, Last)		18. Mother's				
lental rked ic ev	To B	Rogers Lee Sumuel	L	E1:				
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nation any injury or other traumatic event, the Medica once.  To Re Complete		19a. Informant's Name/Relationship (	Type, Print) Sumuel / Wife	19b. Mailing Address (Street and Number of 910 Elton Ave. Ba				
		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 St Other (Specify	Removal from State	lace of Disposition (Name of emetery, crematory or other place)  IOlly Hill Mem. Gdrs.				
		21. Signature of Funeral Service Licer	E Lee	22. Name and Address of Facility Duda-Ruck Funera 7922 Wise Ave.				
within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and page 2 should be detached for use as the burial-transit and page 2.  Medical Certification: To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the Asease, or own shock, or heart fully. Its only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of high) that initiated events resulting in death) Last	a. Cardiac Arrhy  Due to (or as a consequence)   ience of):					
	nysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnat 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pregnancy				
	mpleted by P	Part II. Other significant conditions o	ontributing to death but not resu	ilting in the underlying cause given in Part I.				
ificate or, pag		25. Was case referred to medical		26. Place of				
s cert direct	25. Was case referred to medical examiner?  1 💢 Yes 2 🗆 No		Hospital: 1 ☐ Inpatient 2X I	ER/Outpatient 3 DOA Other: 4 Nursin				
ath, r: After thi ie funeral o	atlon: T	27. Manner of Death  1 Natural  2 Accident  1 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury at Work?  M 1 Yes 2 No				
s after de Il Directo Id in by th	Certification:	3 Suicide 6 Could not be determined						
within 24 hours after death, To the Funerel Director: A completely filled in by the ti	Medical C			wledge, death occurred at the time, date and pl ion and/or investigation, in my opinion, death o				
within To the	Me	29b. Signature and title of certifier	101	29c License number				

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours <u>t√G</u>M 2□ F 458-11-2830 39 Texas July 8,1964 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 910 Elton Avenue 21224 United States 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 NoDesert Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 1 🕏 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Storm Black 16b. Kind of Business/Industry working Trucking Name (First, Middle, Maiden Sumame) izabeth Crawford Rural Route Number, City or Town, State, Zip Code) ltimore, Maryland Date 20c. Location - City or Town, State 4/23/2004 Middle River, MD al Home of Dundalk, Dundalk, Maryland Approximate Interval Between Onset and Death diac or respiratory arrest, 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \[ \] No 24a. Was an autopsy performed? 1 Yes 2 No Death (Check only one) ng Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier O.C.M.E. April 18 18 2004 Year) address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

APR 2 2 2004

DOUTS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dorothy Eleanor Scott \*Physician Year 12:15 AM 2004 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE **Baltimore City** AGNES HEALTHEANE If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1 □ M 2 X □ F 92 218.18.4233 Yrs Director September 1, 1911 Máryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Marvland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21043 3690- B Mt. Ida Drive or Items 23g Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black þ Specify: 3 XWidowed 4 ☐ Divorced "naturel" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Home care iit. Pages 1 and 2 should be filed within riment of Health and Mental Hygiene. If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Domestic 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Williams Eleanor Williams ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4716 Williston Street Baltimore, MD 21229 Ms. Alice Blackstone Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ō 04/22/2004 Catonsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) **Baltimore National Cemetery** permit.
Dep. rtm
Imp. rta
any nju 22. Name and Address of Facility
Slack Funeral Home, P.A 21. Signature of Funeral Service Licen e plumlallen MOUS 35 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician C) 200 isA METABOLIC IVAY /Medical Due to (or as a consequence of): Examiner FAILURE KENAL ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed SEPSIS Due to (or as a consequence of): burial-Box 68760, the IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 4☐Pregnant at time of death Month Day Year 5 Other (specify) the Ö þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Injury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) my 00 60105 as of person who completed cause of death (Item 23a) (Type, Print) AVENUS CATUM KARC 2 2004 32. Registrar's Signature State Registrar

人力しるる

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 [] AMEND ITEM #100&f PER FH C831 5/13/04 JH 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Dey **Physician** Minnie I. Stewart 17, 2004 April 6:00PM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Augusburg Lutheran Home Lochearn Baltimore 8. Date of Birth (Month, Day, Yeer) Jan. 8, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) Funeral Months Deys 1 ☐ M 2 1 F Hours Yrs. 89 Director 220-09-6308 1915 Maryland Usual Residence of Decedent Pagas 1 and 2 should be filed within 72 hours aftar death with the Maryland nant of Haath and Mental Hygiana. Int: If Itam 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County must be notified at 1.□Yes 2□No Funeral Director N/A Baltimore City 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code <del>21205</del> 21236 1<del>022 Iris Avenue</del> 4300 CARDWELL AVE APT 127 United STates 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien 11. Maritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: White Specify: Completed by 3XWidowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfred Paul Hoenig Blanche E. McGee 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Gloria Kimball (Daughter) 6419 Hilltop Avenue Baltimore, Maryland 21206 other 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Department of Important: If II any Injury or o Buriel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Memorial Park 4/22/04 Elkridge, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility
Miller-Dippel Funeral Home, Inc. 6415 Belair Road KI Baltimore, MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner usa as the burial-transit or Attending Physician: The law requires that the death cartificate be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that in its lead of the control o Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or as e consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? funaral diractor, paga 2 should be datached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? been To the Hospital or Attending Physician: Tha law within 24 hours after death.

To the Funeral Director: After this cartificate has 1 ☐ Yes 2 ☑ No TO You BEING 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Manger of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident tha 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, Stete) complately filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner es stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifie completed ceuse of death (Item 23e) (Type, Print) Atto Avenue Baltimore MD 21208 Cl 31. Date filed (Month, Dey, Year) 32 Registrer's Signature State Registrar APR 2 2 2004

	1 - For State Registrar		Ce	rtificate of	Dealii		leg. No.	1 1 2 0 1 2	
Physician	Decedent's Name (First, Middle					2. Date of Dea	Day Yea		
/Medical	George J. S		<del></del>	4h City Tourn	or Location of Death	APRIL	16 200°		
Examiner	4a. Facility Name (If not institution SALAT AGNES	HEALTHAR	-		MORE	4c. County of Death N/A			
	5. Social Security Number		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 F	irthplace (State or Foreign	
ineral rector	212-09-3207	<b>XX</b> M 2□ F	85 Yrs.	Months Days	Hours Min.	August	19,1918 M	country) aryland	
2010	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
any injury or other treumatic event, the Medical Expressionation at once.  To Be Completed by Funeral Director	MD N/A			more City	i <b>7</b>			XXYes 2 □ No	
ect	10e. Street and Number	•	Daici	10f. Zip Code	y	1	10g. Citizen of What	Country?	
Funerai Director	4819 Pleasant View Avenue			21206			United States		
nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		- American Indian,	
/ Fu	1 Never Married 2 Mar	ried 1 XYes 2 No	0	1 Yes 2 No		7 110411, 010.7	1	White	
d by	Widowed 4 □ Divorced	Year or Dates:	23	dent's Usual Occu			16b. Kind of Busines		
jete	(Specify only highe	nt's Education est grade completed)	(Give	kind of work done  DO NOT use retire	during most of work d)	king	100. Killa di basille:	samuustiy	
Completed	Elementary/Secondary (0-12)	College (1-4or 5-	S	tationary	y Engineer	r	Baltimo	ore City	
BeC	17. Father's Name (First, Middle,	Last)					Maiden Sumame)		
To	George Sakiev	ich				ica Matt			
5	19a. Informant's Name/Relation: Nicholas Pelle						r, City or Town, State		
	20a. Method of Disposition	grini (3011-11					20c. Location - City		
[	1 Burial 2 □ Cremation		20b. Place of Dispo		al Cemetei	/04		, Maryland	
ei.	'4 □ Donation 5 □ Other (3							,	
ouce	Medial	Januar 1	101521 B	iller-Di; 415 Bela:	ess of Facility opel Fune: ir Road	ral Home Raltimor	, inc. e. MD 2120	06	
	23a. Part1. Enter the disease, of	r complications that caused t only one cause on each line	the death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between	
an	Immediate Cause (Final disease or condition	SEP						24 Hours.	
al er	resulting in death)	a	consequence of):						
	Sequentially list conditions,	b. — Our to /or or o	consequence of:						
Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):						
Exar	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):						
call		d							
	IF FEMALE:								
Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 ☐ Fetal death 3 〔	⊒Ectopic pregnanc	;y		23d. Date of o	lelivery Day Year	
/sici	1 Yes 2 No	4☐Pregnant at t 9☐Unknown	time of death 5[	Other (specify) _					
Ph	Part II. Other significant condit	ions contributing to death bu	t not resulting in the u	inderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?	
d b	DIABETES MELLITUS TYPE 2.				1 Yes 2 No 3 Probably 4 Bonknown				
Completed by						24a. Was a	an 24b. Were	autopsy findings available	
mo						autops perfori	med? death 2 No 1 ☐ Y	o completion of cause of ? es 2 X No	
BeC	25. Was case referred to medic	al			26. Place of Dear	th (Check only or			
To B	examiner? 1 ☐ Yes 2 ♣ No	Hospital: 1 Inpatier	nt 2 ER/Outpatie	nt 3 DOA	her: 4 🗌 Nursing H	ome 5 🗆 Reside	ence 6 Other (S)	pecify)	
uo:	27. Manner of Death Natural 5 Pend	28a. Date of Injury (Month, Day	Yeer) 28b. Time of Injury	Wo		28d. Describe he	ow injury occurred		
Medical Certification; To Be C	2 Accident invest	igation at he	Athema farm		Yes 2□No	29f Location (St	treet and Number or	Pural Pouta Number	
Certification:	4 Homicide deten	nined 286. Place of inju	ry - At home, farm, st . <i>(Specify)</i>	reet, factory, office		City or Town		riurai rioute rvambor,	
S		ng Physician: To the best o							
Medicai		Examiner: On the basis of and manner star	examination and/or in						
Me	29b. Signature and title of certific	er			se number		29d. Date signed (Mo	nth, Day, Year)	
	Pototic M	· D.			0702			0,2004	
	30. Name and address of person	who completed cause of de	eath (Item 23a) (Type,	Print)	. \	0		141	
	T		COURT.		1 21 10 1	. L A L L L L L L L L L L L L L L L L L	L-8	Max aracic	
State	ERINLE, Ayot 31. Date filed (Month, Day, Yea		900 Sou7	"H CATO	m HUEN	ue, lof	+CTIMORE	MB 21229	

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of N	naryia				leaith and Death	Mental Hy	rgiene Reg. No. 2 (	ากน	12	5.73
	Physicia: /Medica			e <i>(First, Middl</i> e, Las arie Stu	ckert						2. Date of Do Month April	Day 16, 200	Year )4	3. Time	of Death p.m.
	Examine		4a Fecility Neme (/	f not institution, give	street end numbe	or)				4b. City, Town, o	r Location of Dee				
	Funeral Director		5. Social Security N 216-74-	9691		Age (In yrs	s. <i>l</i> est birthdey) Yrs.		der 1 Year is Days	Lochea:	s. 8. Date of Bi	rth ay, Year)			e or Foreign
	how	Ī	Usuel Residence of 10a. State	Decedent 10b. County		10c. C	ity, Town or Lo	cation					10		City Limits
	Se-f	$ar{\mathbf{g}}$	MD	Baltin	nore		Lochear	'n							s 2 No
	vith th	5	10e. Street end Nur					10f.	Zip Code			10g. Citizen of	What Coun	try?	
	a 23	<u>a</u>		mpfield I	Road 12. Was Deceder	of Ever in I	10 10 1	Was Da		207	Enosity Ves es N		ed Sta		
020	urs efter deeth with the Manylar al', or Hems 23a or 28a-f show Examiner must be notified at	D Y	<ol> <li>Marifal Sfatus</li> <li>Never Marri</li> <li>Widowed</li> </ol>	ed 2 Married 4 Divorced	Armed Forces  1 Yes 25  If Yes, Give A  Yeer or Dates	s? No	1			Specify:	Specify Yes or Norto Rican, etc.)		ck, White, o	etc.	
Maryland 21215-0020	n 72 ho	paraduios	(Specification (Speci	15. Decedent's Ed ify only highest gree ndary (0-12)	ucation de co <i>mpleted)</i> College (1-4o	r 5+)			sual Occup work done use retired	ation during most of wi	orking	16b. Kind of B	usiness/Ind		
d 2	be filed withing tal Hygiene.		17. Father's Neme	(First, Middle, Last)				· · · · · · ·	acres	18. Mother's Na	ame (First, Middle				
lan		ם	Martin Kossman							ertha Mi					
ary	2 should end Men is marke aumatic	_	19a. Informant's Name/Relationship (Type, Print)  Ruth A. Stuckert (Daughter)  19b. Mailing Addrass (Street end Number)  4511 Woodlea Avent										Stete, Zip	Code)	
	s 1 and 2 f Haalth flem 27 i	⊢			(Daughter	-						re, MD			
Baltimore,	Pages 1 nent of H nit: If Iter iry or off		20a. Method of Disp Tx∑TBurial 2 [	Cremetion 3	Removal from Stat		Place of Dispo cemetery, cren				Date	20c. Location -			
Ħ.	it. Pa rtmen rtant: njury		4 Donetion	5 ☐ Other (Specify	)	Pa	rkwood				4/20/04	Baltimo	ore, l	Maryl	.and
Ba	permit. P Departm Importar any injur		21. Sig atu of Fu	abith	Selen	ich	A M	$i11\epsilon$	r-Dir	ss of Facility opel Fun Lr Road	eral Hom Baltim	e, Inc. ore, Man	ryland	1 212	206
	Physician /Medical Examiner	1	Immediate Ceuse ( disease or condition resulting in death)	e disease, or comp t failure. List only o Final n	a. END S	TA68		este	MEY					Intérval B Onset and	d Death
x 68760,	ding physician and see es the buriel-trensit	200	Sequentially list coif eny, leading to im cause. Enter Unde Ceuse (Disease or thet initiated events resulting in death) I	ast	c		or as a conseq								
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0.	w raquiras that the death cert been signed by tha attandim should be detached for use	,	Part II. Other signifi	cant conditions co	ntributing to death	but not re	sulting in the ur	nderfying	cause giv	en in Pert I.		tobacco use co Yes 2 ☐ No			of death?
Vital Records,	The law raquira: pate has been sig	200									24a. Was	en autopsy ormed?	ava	re autopsy ilable prior opletion of eath?	y findings r to f cause
<u> </u>	The law ate has be pege 2 s										10	Yes 2 10	10	Yes 2	€1No
VII:	Physician: The lave this certificate has ral director, pege 2	3	25. Was case referrexaminer?	/	Hospital:				Oth		ath (Check only				
ō	ing Physician: h. After this certific funeral diractor,		1 ☐ Yes 2 € € € € € € € € € € € € € € € € € €	NO	1 ☐ Inpat 28a. Date of In (Month, D	iurv	28b. Time of Injury	t 3⊡ I	28c. Injun Worl	4 Privursing	Home 5 🗆 Resi 28d. Describe	dence 6 □Oth how injury occur		)	
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After tompletely filled in by the funeral Medical Certification:		2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Pleca of la building, e	njury - At h etc. <i>(Speci</i>	nome, farm, stre	eet, facto			28f. Location ( City or To	Street and Numb wn, Stete)	er or Rural	Route Nu	ımber,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in Martical Cart		29a. Certifier (Check only one)	1 ∠ Certifying Phy 2 ☐ Medical Exami	sician: To the besiner: On the besis end manner s	of examina	owledge, death ation and/or inv	occurre estigation	d at the tin on, in my o	ne, date end plac pinion, death occ	a, and due to the urred at the time,	ceuse(s) and ma date and place,	inner as sta and due to	ited. the cause	o(s)
	Within To the comp		29b. Signature end	title of certifier	7				9c. License			29d. Date signe			
	$\cap$		Melto	min & fe	en			1	4459	3/		April 1	19 24	04	
	46		30. Name and eddre	ah I f	lierce	72	m 23a) (Type, 1 20 Pa	Print)	Hey	hes Au	enue	Bolton	core	MD	2/208
	State Registrar	4	31. Date filed (Mont	R2 2 2 200	4 Regis	trer's Sign	ature de	AL.							

DHMH 16 Rev 6/95

				1 - State Registrar	tate of Ma	ryland / Depa <i>Cei</i>	rtment of He			ne . No. 2 () (		71
	I	Physici		Decedent's Name (First, Middle, Last)	m. c.	-			2. Date of Death Month	Day	3. Time of C	Death M
		/Medic Examir		WASHINGTON 4a. Facility Name (If not institution, give stre		KER	4b. City, Town, or L		PR. 22,	2004 4c. County o	9:45 <i>a</i> f Death	<u>1m</u>
				JOSEPH RICHIE HOS  5. Social Security Number 6. Sex	SPICE 7. Age	(In yrs. last birthday)		LTIMORE If Under 24 Hrs.	8. Date of Birth		NA 9. Birthologo (State or	Comign
		Funeral Director			2□F	57 Yrs.		Hours Min.	(Month, Day, Yo	947	9. Birthplace (State or Country)  MD	
		yland how		10a. State 10b. County		10c. City, Town or Lo	cation	-			10d. Inside City	/ Limits
		Ba-f.	ctor	MD NA		BA	LTIMORE				1∭Yes 2	2 🗌 No
		with the a or 2	2	10e. Street and Number			10f. Zip Code		10g	. Citizen of Wh		
		death with the Maryland ms 23a or 28a-f show Livest be notified at	Funeral Director	735 E. 21st. STRI	Was Decedent Ev	ver in U.S. 13. V	Vas Decedent of Hisp Yes, specify Cuban,	21218 panic Origin? (Spe	cify Yes or No-	US 14. Race	- American Indian,	
	92		y Fur	1 XNever Married 2 Married	Armed Forces? 1	)	Yes, specify Cuban,		Rican, etc.)	Black	AFRICAN	
	Ö	172 hours after death with the Marylar Tastural', or Items 23a or 28a-f show	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Education	Year or Dates:		ent's Usual Occupation		161	b. Kind of Bus	AMERICAN	
	215	V C -	Completed	(Specify only highest grade co	mpleted) College (1-4or 5+	(Give	kind of work done dur OO NOT use retired)	ring most of workin	ng loi	o. Kirid of Bus	mess/maastry	
	21	led wit ygiene her tha		12th	0			RKED			NA	
	and	d be fill intal H ad ott	Be	17. Father's Name (First, Middle, Last)	TUCKER		1		(First, Middle, Mai		)	
2	aryl	should and Me mark umatio	P <sub>C</sub>	WASHINGTON  19a. Informant's Name/Relationship (Type,		19b. Mailin	g Address (Street and			LEWIS ity or Town, S.	tate, Zip Code)	
10	Z,	and 2 saith a n 27 ls		GLORIA TUCKER (SI	STER)	124 W	• FRANKLI	IN STREET	1311			
22/04	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic svent, Item Moone.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Remo	oval from State	20b. Place of Dispos cemetery, cren	sition (Name of natory or other place)	1			ity or Town, State	
7	Ħ	nit. Pa artmer ortant: Injury		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signat ☐ Funeral S ☐ ce Licensee			EMATORY Name and Address	4/22/			ILLE, MD	
5	Ba	Depar Impo any Ir		Markon /h	May		38 N. GILM		LIE FUNE T BALTII	MORE, N		
	I			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one c	ons that caused the	e death. Do not ente	or the mode of dying,	such as cardiac or			Approximate Interval Between	een .
3		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	01	17/6	TYCIN	10 mo			Ortset and De	0
4		Examiner			Due to (or as a	consequence of):					<b>V V V V</b>	
57		B =	ner	Sequentially list conditions, harry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a	eonsequence of):						
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,	8760,	cate be executed obysician and the burial-transif	dical E		Due to (or as a	consequence of);						
3	687	tificate ng physias the	fedic	0.								
3	Вох	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as i	Physician/Me	in the past 12 months?	If yes, outcome of 1□Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date	,	
13	0.	the dear	ysici	1 Yes 2 No	4□Pregnant at tii 9□Unknown	me of death 5	Other (specify)			Month	n Day Yea	ar
1	4	res that the d igned by the be detached	by Ph	Part II. Other significant conditions contrib	uting to death but	not resulting in the un	derlying cause given	in Part I.	23e. Did tobace	co use contrib	ute to the cause of dea	athe
2	ecords,	w require been sig should b	ted b						1 🗆 Yes	2 □ No 3	Probably 4 Doni	known
4	Sec.	e law r has be je 2 sh	Completed						24a. Was an autopsy	24b. We	ore autopsy findings av	allable ise of
5	<u>a</u>			or Manager of the first					performed 1 ☐ Yes 2		ath? Yes 2□ No	
3	f Vital	Attending Prysician: The robath.  octor: After this certificate his property of the funeral director, page	o Be	25. Was case referred edical examiner?  1  Yes  No Hosp	ital: 1 ☐ Inpatient	2 ER/Outpatient		6. Place of Death  4 □ Nursing Hom	Check onlone  Be 5 Residence	6 i⊓Other	(Soudot NIST)	21/1
ashe	n of	ding Phys h. After this funeral di	on: I	27. Manna of Death 1 Pending 2	8a. Date of Injury (Month, Day	A Comment of the Comm	28c. Injury at Work?	t 21	8d. Describe how in			CC
2	Division	ottendi death. ctor: A y the fu	icati	2 Accident investigation	On Diagonal Initia		M 1 TYes	s 2□No	05 h 1i (Ot		2 10	
	Di≤	in it is	Certification:	4  Homicide determined	building, etc.	y - At home, farm, stre (Specify)	et, ractory, office	20	City or Town, S	tand Number late)	or Rural Route Numbe	ď.
/	/:	To the Hooppher of within 24 hours at To the Funeral Completely filled in		29a. Certifier (Check only 2 Medical Examiner:	On the basis of e	xamination and/or inv	occurred at the time,	date and place, ar	nd due to the cause	e(s) and mann	er as stated.	
1		To the Mithin 24	Medical	one)  29b. Signature, and tale of certifier	and manner state	d.	29c. License ni			- 1	Month, Day Year)	
		F 3 F 8		Valle 11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	Alm	0	17/1	3010		4/1	2/14	
	•	1		30. Name and address of person who camp	eted cause of dea	thy(Item 23a) (Type	rint)	111	1 1.1	1 11	101	1
		1		JOHN WI POU	116 4	311 1/11	GEV UC	00 KM	20110	1,114	12/2/8	
		Sta Registr		APR 2 2 2004	Serendistrar.	s Signature	Park!	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Emily L. Taylor 3,2004 APRI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months 1 □ M 2 🕅 F 218-03-2953 83 Director June 2, 1920 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar coust be notified at MD Baltimore Cockeysville 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10535 York Road #245 21030 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ğ Specify: white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) bookkeeper financia1 i. Pages 1 and 2 should be filed vitment of Health and Mental Hygie rtant: If item 27 is marked other thinry or other traumatic event, II. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Reed Larmore Sylvia Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 Is any injury or other trau Stephanie Taylor/adopted daughter 1415 Park Avenue #2 Baltimore MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 X Donation 5 ☐ Other (Specify) 21. Si natur of Funeral Service Licensee Ronal S. Wade 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street macen 23a. Pan 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as attending I for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ANEMIA 1 Yes 2 No 3 Probably 4 Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy perform formed? 2 **X** No 2 No 1 Yes 1 Yes spital or Attending Physician: hours after death. Increase Director: After this certifically filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 04 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

BOON P.

31. Date filed (Month, Day, Year)

MPR 2 2 2004

LIM M.D.

TOWSON MARYLAND

7601 OSLER

32. Registrar's Signature

		1 - State Registrar	1-(la   la as)			Cei	rtifica	te of D	eath	1 0 Data o	Reg. N	20	04	12571
Physici /Media		1. Decedent's Name (First, Mic Dorothy The	riault				,			2. Date o		)ay 19	Yeer 2000	3. Time of Death
Examir	ıer	4a. Fecility Name (If not institut 524 Williamsburg			(r)			Odento			4	lc. County		Arundel.
Funeral Director		5. Social Security Number 005–56–3454  Usual Residence of Decedent	6. Sex 1 □	м 2 <b>/2</b> /2F	Age (In yrs. 87	last birthday) Yrs.	If Und Months		Hours Min	. (Month	Birth Day, Yea 5, 1	916	9. Birthp Coun M	lace (State or Foreign try) E
death with the Maryland ms 23a or 28a-f show I must be notified at	tor	10a. State 10b. Cour	Arund	el.	10c. Ci	ty, Town or Lo		entan					1	0d. tnside City Limit
h with the 13a or 28a	Funeral Director	10e. Street and Number 524 Williamsburg	g Lane				10f. Z	ip Code		21113	10g. 0	Citizen of \	What Coun	itry?
be filed within 72 hours after death with the Marylan Ital Hygiene. ad other then "naturel", or items 23a or 28a-f show event, the Medical Examinet must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ M 3 ☑ Widowed 4 ☐ Divorc	arried	2. Was Deceder Armed Force: 1  Yes 2 5 tf Yes, Give Year or Dates	s? <b>}</b> \o	f	Was Dec If Yes, sp		anic Origin? (S Mexican, Puer Specify:	Specify Yes of to Rican, etc.	No-		ck, White,	
e filed within 72 ho al Hygiene. I other then "natur vent, Ine Medical	Completed	15. Deced (Specify only high Elementary/Secondary (0-12 12.		ation completed) College (1-4o	r 5+)	16a. Deced (Give life.	kind of w	ual Occupation done dur use retired)	on ing most of wa	rking	16b.	Kind of B	usiness/Ind	•
2 should be filed and Mental Hygi is marked other aumatic event, I	To Be C	17. Father's Name (First, Middle Beniah Lapham						11	B. Mother's Na	me (First, Mic Sarah ]		an Suman	ne)	
nd 2 sh lith and 27 is m r traum		19a. Informant's Name/Relation  Judy Carson / I							Number or R				State, Zip	Code)
9 0 ≈ 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		emoval from Stat		Place of Dispo cemetery, crer verside			pril 26,	Date 2004		Location -	City or To	wn, State
permit. Pa Departmen Important: eny injury once.		21. Signature of Funeral Service	ce Ligansa	• Victor	P. Doo	a, Jr. 22	harle 1501 I	and Address of St. St. For	of Facility Devens Fu t Avenue	neral H	me, li	nc.	30	
Physician		Immediate Cause (Final	ast only one	o vause on each	mio.			ale or aying,						Approximate
/Medical Examiner  Associated and and and and and and and and and an	cal Ex	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<ul><li>a.</li><li>b.</li><li>c.</li><li>d.</li></ul>	Due to (or a	ent is a consec ly be	quence of): ) men quence of):	ebr.	ode of dying,	ular Dicea	acer ie	den	1	0	Interval Between Onset and Death RENUL CHARLE CHARL
death certificate be executed  e attending physician and id for use as the burial-transit	cal Ex	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. b. c. d.	Due to (or a	is a consecutive of pregnate of pregnate at time of d	quence of):    uence of):	ebri	pregnancy	ulen Ti cea	acer Le	den	23d. Dat	te of delive	Interval Between Onset and Death Albuth
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ding Physician: The law requires that the death certificate be executed by the attention of the certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit of the certificate has the certificate of the cert	Certification: To Be Completed by Physician/Medical Ex	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	cal Ho	Due to (or a  Due to (or a  Due to (or a  Due to (or a  Due to (or a  Due to (or a  Due to (or a  Due to (or a  Due to (or a  Due to (or a  Due to (or a  Due to (or a	is a consection of the consect	quence of):  quenc	DEctopic   Other (standardying)  M  eet, factor	oregnancy ppecify)  cause given  28c. Injury at Work? 1   Yes	in Part I.  6. Place of De. 4 Nursing H	23e. D  24a. W a p 1   Ye ath (Check or City or	As an utopsy arrormed? S 2 V/s s 2 V/s one)  esidence be how injunctions of the cause!	23d. Dai Mo  use cont 2 No  24b. V	nibute to th  3 Proba  Were autoprior to condeath?  Yes  er (Specify)  ed  er or Rural	Interval Between Onset and Death Onset and Death Certification of Cause of death?  Property of the Cause of death?  Property of the Cause of death?  Property of the Cause of death?  Property of the Cause of death?  Property of the Cause of death?  Property of the Cause of death?
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ding Physician: The law requires that the death certificate be executed by the attention of the certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit of the certificate has the certificate of the cert	Certification: To Be Completed by Physician/Medical Ex	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	cal Hoding stigation Id not be amined straightful to the fifter fifter for the straightful to the straightfu	Due to (or a  Due to (or a  Due to (or a  Due to (or a  Due to (or a  Due to (or a  Due to (or a  Due to (or a  Due to (or a  Comparison of the comparison o	is a consection of pregnation of examinastated.	quence of):  June (  quence of):  quence of)	DEctopic plant of the state of	oregnancy pecify)  cause given  28c. Injury al Work? 1   Yes	in Part I.  6. Place of De. 4 Nursing F.  2 No  date and place on, death occu	23e. D  24a. W a a 1   Ye ath (Check or City or  28f. Locatio City or	den  Yes  As an attopsy esidence be how injury one)  In (Street a Town, Sta.)  The cause(ine, date ar 29d. D	23d. Date Moon was control of 24b. Value of 150 and Mamb and place, at a signed	nibute to th  3 Proba  Were autoprior to con leath?  er (Specify red  er or Rura)  nner as sta and due to  1 (Month, L	Interval Between Onset and Death Onset and Death Church Ch

### Piease Type or Print in Biack Indelibie ink. Assure Ali Copies Are Legibie.

			Amend Item 24a per Verb, 6830, 04, 227, 140 hb Certificate of Death	nd Mental H	ygiene Reg. No. 201	L 1257
			1. Decedent's Neme (First, Middle, Last)	2. Dete of D	Deeth	3. Time of Death
-	Physici /Medi		Leroy Thacker	March	19, 2004 Year	8:20 AM
di	Examir			n, or Location of Dee		
			Pineview Nursing Home Clinto:  5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24			George's
ы	Funeral Director			Min. June	Jay, Year	irthplace (State or Foreign Country) Shington DC
co.			Usuel Residence of Decedent			
	anylar show	<u>_</u>	10a. Stete   10b. County   10c. City, Town or Location   MD   Prince George's   Capitol Heights			10d. Inside City Limits 1 ☐ Yes 2∑ No
	ours after death with the Marylar el', or items 23a or 28a-f show Examiner mant be notified at	Director	10e. Street end Number 10f. Zip Code		10g. Citizen of What C	
	3a or	Ö	1//0 37		USA	ountry !
	ter death Items 2:	Funeral	11. Marital Stetus  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or N		
0	or ite	Ē	Armed Forces? If Yes, specify Cuban, Mexican, F  1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 ☒ No  If Yes, Give I ☐ Yes 2 ☒ No Specify:	Риепо Hican, etc.)		
005	within 72 hours after death with the Maryland ene. than "naturel", or items 23s or 28s-f show he Madical Exeminer must be notified at	d by	3 Widowed 4 Divorced Year or Dates:			black
5	n 72	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most on life. DO NOT use retired)	f working	16b. Kind of Busines	s/Industry
212	d withir	E	Elementary/Secondary (0-12) College (1-4or 5+) Laborer		constru	action
pu	흥독활분	BeC		Name (First, Middl	le, Maiden Sumame)	unk
Maryland 21215-0020	Men Men mrke	2				
Mar	CI		19a. Informant's Name/Relationship (Type, Print)  Marie Vela/sister  19b. Mailing Address (Street and Number of A714 B Street SF. Was		-	Zip Code)
ō,	s i end f Health ftem 27 other to		20a. Method of Disposition 20b. Place of Disposition (Name of	shington,	DC 20019 20c. Location - City o	r Town. State
Baltimore,			1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 🖔 Other (Specify) in State			
altii	permit. Page Depertment Important: If any Injury or pace.		21. Signature of Euneral Service Licensee 22. Name and Address of Fecility			
Ö	S S S S			ard 655 W 1201	. Baltimore	Street
			23a. Pent . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es ca shock, or heart failure. List only one cause on each line.		arrest,	Approximate Interval Between
	Physician					Onset and Death
46	/Medical Examiner		Immediate Ceuse (Final disease or condition oropharyngeal carcinoma resulting in death)			1
		Je.	Due to (or as a consequence of):			1
	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions.  Due to (or es e consequence of):			
0,	daath certificate be executed e ettending physician and ed for use as the bunal-transit	Ex	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or injury			[ [
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P.O.	t tha c by the lached	hys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			e to the cause of death?  Probably 4 Unknown
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of Vital Records,	v requiras that tha been signed by th should be detach	Completed by			s an autopsy 24b. omed?	Were autopsy findings available prior to
Sec.	_ 11 0	힐				completion of cause of death?
a	: The icata r, pag			10	Yas 24110	1 ☐ Yes 2 ☐ No
₹	Physician: r this certific rrel director,	o Be	examiner?	Death (Check only	one) idence 6 ☐Other (Spe	
9	g Phy er this serel o	n: To	27. Manner of Deeth 28a. Date of Injury 28b. Time of 28c. Injury et		how injury occurred	эспу)
Sio	Attending r death. ector: After by the fune	atio	2 Accident investigation M 1 Yes 2 No			
	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or R wn, State)	lural Route Number,
	pital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and p		( )	
	To the Hospital or Attending Physician: The law within 24 burors after death. To the Funerel Director: After this certificate has completely filled in by the funerel director, page 2.	edical	29a. Certifier  (Check only one)  Check only one)  Certifying Physician: To the best of my knowledge, death occurred et the time, date and p (check only one)  Medical Examiner: On the basis of examination end/or investigation, in my opinion, death cand manner steted.	occurred at the time,	, date and place, and du	s steted. e to the cause(s)
	Vithir To th	Me	29b. Signature end title of certifier 29c. License number		29d. Date signed (Mon	th, Dey, Yeer)
			) (8 D 51520		3-29-0	4
-			30 Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)	11.	105 1 6 10	16
			31. Date filed (Month, Day, Year) 32/Registrer's Signature	J PU	1.21100	Nome
	Sta Registra		APR 2 2 2004  APR 2 2 2004			

		1 - For State Registrar		aryland / Depa	artment of Heartificate of De		Reg. No.	4 12578
	Physiciar /Medica	I Subci II. I	rotta			2. Date of D Month April	21 2004	9:40a M
	Examine uneral	Joseph Rich	ey Hospic	e (In yrs. last birthday)		CC Under 24 Hrs. 8. Date of B	4c. County of De	Birthplace (State or Foreign
D	irector	Usual Residence of Decedent  10a. State  10b. County	1□M 2 <b>ĕ</b> F <b>7</b>	4 Yrs.		Min. (Month, E 1 – 1 4 –	1930 Ba	altimore, MI
death with the Maryland	Sa-fahor			Baltim	ore			10d. Inside City Limits 1 X Yes 2 ☐ No
ath with t	in Items 23a or 28a-fal	10e. Street and Number 144 S. Highla			10f. Zip Code	21224	10g. Citizen of What	
<b>1036</b> ours after de	Examiner	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10		nic Origin? (Specify Yes or N lexican, Puerto Rican, etc.) pecify:	o- 14. Race - Ar Black, WI Specify: W	
Maryland 21215-0036 to 2 should be filed within 72 hours aft th and Mental Hyolene.	t, the Medical E	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		16a. Deced (Give life. COS	lent's Usual Occupation kind of work done durin DO NOT use retired) Metologis	n ng most of working S <b>t</b>	16b. Kind of Busines Salon	ss/Industry
yland 2 ould be filed	larkad othe	Walter Fleming	g		M	Mother's Name (First, Middle largaret Rei	d	
Baltimore, Mar	Important: If item 27 is marked other than "natural", or liems 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be multiled at once.  To Be Completed by Ermoral Disortor	19a. Informant's Name/Relationship Benjamin Trot  20a. Method of Disposition  1X Burial 2 Cremation 3	□Removal from State	1 4 4 20b. Place of Dispo cemetery, crer		Number or Rural Route Numb and Ave., Ba Date 4/24/2004		MD 21224 or Town, State
- 1	Importan any injur, once.	'4 □ Donation 5 □ Other (Spe 21 Signature of Funeral Service Lie				Facility Joseph N	. Zannino	Jr. FH
, ,	sician edical	234 Part1. Enter the disease of or conshock, or heart failure. Lust or immediate Cause (Final disease or condition resulting in death)	a. Mal	the death. Do not ent le.		uch as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death  8 Man-Hhs
3760, A 21,	ysician and be burial-transit and call Examiner		b Due to (or as a	a consequence of): a consequence of): a consequence of):				
Box 6	the attending phed for use as	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	100	23d. Date of do	elivery Day Year
cords, P.O	b ed	Part II. Other significant conditions	contributing to death bu	_	derlying cause given in		obacco use contribute Yes 2 \( \text{No} \) 3 \( \text{F} \)	to the cause of death?  Probably 4 Onknown
I Rec	2 2 5					24a. Was auto perfc 1 \( \triangle Yes		
on of	After this funeral dii	examiner? 1 Tes 2 Volo	28a. Date of Injun (Month, Day)	ry - At home, farm, stre	3 DOA Other: 4  28c. Injury at Work?  M 1 Yes	2 🗆 No	dence 6 Kether (Spendown injury occurred	•
ha Hospital	ha Funar pletely fill edical	29a. Certifier Certifying (Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner stat	examination and/or inv	occurred at the time, destigation, in my opinion	ate and place, and due to the n, death occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To t	To t	29b. Signature and title of certifier  **Bont B. 7	Macdonald, i		29c. License nun		29d. Date signed (Mon	th, Day, Year)
5	0.		completed cause of de acdonald	eath (Item 23a) (Type, F 2400 K 's Signature	rint) IRK Avanue	, Baltmore,	MD 212/	3
	State Registrar	ADD 0 0 000 *	stera ma	19 A	raiks			

DOS 04 - 2525Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Wilmond Tucker State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day April 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harbor Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Gountry) 8. Date of Birth (Month, Day, Year) 100M 20F Director 28. 1919 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits ?7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Madical Exertiner must be notified at by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 123 Cher 946 death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or the Important: if item 27 is marked other than "natural", or the Important or other traumatic event, the Madical Examines one. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, U) ILLIams (daughter 91 NA 3215 WINDSOT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 120 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) RDAR HILL Cem. 22. Name and Address of Facility TRI State 7/5/2 21. Signature of Funeral Service Licensee 3 Ad St. NW. Wash 24a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Smoke whatation Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Disa to (or as a consequence of) as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 2 🛱 No 3 Probably 4 Unknown Completed 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 🗌 Yes 21**A** No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 XYes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 🖾 No 2 Accident investigation 4-13-04 10:40 AM 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 123 home

To the Hospital or Attending Physician: The law requites that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 2 should be deached for use as the burial-transit completely filled in by the funeral director, page 2 should be deached for use as the burial-transit Japitar L.
4 hours after dea.
- real Director: After

victim of house fire 28f. Location (Street and Number or Rural Route Number, City or Town, State) cherry La

<u>11</u>45

1 Yes 2 No

Year

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

M. D

29c. License number OCME

29d. Date signed (Month, Day, Year) April 14, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LING LI m.D 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) State APR 2 2 2004 Registrar

29a. Certifier

(Check only

Medical

32. Registrar's Signature

04-2535 B.K.S BROCK T

(.S	TUCKEF	)	Please <sup>-</sup>	Гуре or Print in Black In			_	
For State of Walfyland / Department of Health and Wental Hyglerie  1 - State Registrar  Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Date of Death  2. Date of Death								10500
	Physici /Medi		1. Decedent's Name (First, Middle, Last	in I		2. Date of Death	Day Year L3, 2004	3. Timer of Beath C
	Examir		4a. Facility Name (If not institution, give NORTH ARUNDEL HOS	SPITAL	4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE AR	
	Funeral Director		213-41-7715	X 7. Age (In yrs. last birthday)  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yei Feb. 20, L	9. Birth	nplace (State or Foreign untry) THA Carolin
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hyghene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic event, It's Marical Exter-threat Le rotified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  10e. Street and Number  330 RICH MO  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edi (Specify only highest grace)  Elementary/Secondary (0-12)  3 RP  17. Father's Name (First, Middle, Last)  Brock Elementary (15)  19a. Informant's Name/Relationship (17)  20a. Method of Disposition  1 Burial 2 Cremation 3 February (15)  21. Signature of Funeral Service Licens	1   Yes , Sive Year or Dates:  Ication (6 completed) (6 Give life).  College (1-4or 5+) (700, Print) MOTHER 19b. Mailing (1-4or 5+)  Removal from State (20b. Place of Dispontant Control of Control o	Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 □ No Specify:  Ident's Usual Occupation kind of work done during most of working to NOT use retired)  18. Mother's Name Parallel Number or Rural Number of Rural Number or Rural Number or Other place)  19. Name and Address of Facility 1.2.  10. Name and Address of Facility 1.2.	acity Yes or No-Rican, etc.)  16b.  (First, Middle, Maid  Al Route Number, City  (Al Route Number, City  (Al Route 20c.)	allace y or Town, State, Zi Ne LLU'ILLE Location - City or T OCK / YX	ican Indian, o, etc.  ack  industry
	cate be executed  Division and  The buriat-transit  The buriat-tra	Examiner	2 Fan Enter the disea or company of the control of	Lications that caused the death. Do not ent ne cause on each line.  a. Smoke www.  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):			ash, DC	Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE		]Ectopic pregnancy		23d. Date of deliv	ery Day Year
Records, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions co	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to t 2 ∰No 3 □ Pro	the cause of death?
	iician: The law r certificate has be rector, page 2 sh	Be Completed	25. Was case referred to medical examiner?		26. Place of Death	24a. Was an autopsy performed? 1 Yes 2 X N	prior to co death?	opsy findings available impletion of cause of
of	or Attending Phys ifter death. Director: After this in by the funeral dii	Certification; To	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide	Associated to the property of	28c. Injury at Work?  M 1 □ Yes 2 1 No  eet, factory, office 2	8f. Location (Street	ury occurred  f howse and Number or Rura te) 123 Cha	2 fir 2
	To the Hospital within 24 hours a To the Funaral I completely filled	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, a	and due to the cause/	e) and manner as e	tated. the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	m.0	29c. License number O.C.M.E		PRIL 14,	Day, Year) 2004
	4		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type.  M · A 111 Pen	rint) n Street, Baltimor	e, Maryla	nd 21201	

State Registrar 1. (NG LI
31. Date filed (Month, Day, Year)
APR 2 2 2004

32. Registrar's Signature

DOS 04-2524 Hannah Tuc

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

ah	Tucker		r icase i	State of Manyland / Der	natment of Health and I	•		
			1 - State AMEND THEM	#5 PER INF G 832 G	extificate of Death	- 0	. No. 2004	12501
			Registrar ATILIVD TTLIT      Decedent's Name (First, Middle, Last)		77777640 JE Dodan	2. Date of Death		3. Time of Death
	Physici		HANNAH	Tucker		April 13	3, 2004	1145 a M
7	/Medio Examir		4a. Fecility Name (If not institution, give : Harbor Hospital	street and number)	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
	Funeral Director		219 50 0120	7. Age (In yrs. last birthda M 2DF 75 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day, You	ear) 9. Birth Cou	place (State or Foreign intry)
	show		Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location /			10d. Inside City Limits
	the M	Funeral Director	MD AA	Glen	BURNIE 101. Zip Code	10a	Citizen of What Cou	Yes 2 No untry?
	th with 23a or	ai Di	123 Cheri	ry Lane	21060		USA	
36	after dea or Items	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 DNo If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: R	can Indian, , etc.
5-0036	72 hours natural;	ted	15. Decedent's Edu (Specify only highest grade	cation 16a. Dec	edent's Usual Occupation re kind of work done during most of wor DO NOT use retired)	ting 161	b. Kind of Business/In	ndustry
2121	d within jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) S7	Ate Lead AiD	D. D.	ept so	C. Service
pu	be filed ital Hygi id other event,	Be	17. Father's Name (First, Middle, Last)	Nable	18. Mother's Nam	ne (First, Middle, Mai		+-
Maryland	s 1 and 2 should be filed f Health and Mental Hyg Item 27 is marked othe other traumatic event,	ဥ	James Ve		iling Address (Street and Number or Ru	1	ity or Town State Zin	n Code)
	alth ar 27 is or trau	1		LIAMS 32	15 WINSOR	3lVD.B	AltoIMI	21207
ore,			20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □ R	emoval from State 20b. Place of Dispersion Company Com	position (Name of ematory or other place)	1	. Location - City or To	
altimore,	nit. Pages artment of ortant: If It injury or o		' 4 □ Donation 5 □ Other (Specify)	CEDA	RHILL Cemi 4/2		rook ly	N.PK.MI
Ba	Depa Impo any is		21. Signature of Funeral Service License		22. Name and Address of Facility	~	vashit	LNCI
l mai	N <sub>e</sub> -		ia. Part1. Enter the dialism, or small pli shock, or heart failure. List only or	cations that caused the death. Do not e				Approximate Interval Between
	Physician	3 13	Immediate Cause (Final disease or condition		mhalation			Onset and Death
	/Medical Examiner		resulting in dealh)	Due to (or as a consequence of):				
		er	Sequentially list conditions, I any, leading to immediate	Directo (or as a consequence of):				
	cuted or ransit	cause, Enter Undertying Cause (Disease or injury that initiated events c.						₹
760,	be exec ician an burial-tr		resulting in death) Last	Due to (or as a consequence of):				-
687	physicate t	edicai	, d					
Вох	he death certificate be executed the attending physician and ched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
, P.O.	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	he cause of death?
Records,	en sig	ed b				1 🗌 Yes	2 ANo 3 Prob	bably 4 Unknown
ecc	a S	Completed				24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
a H						performed 1 ☐ Yes 2 💢	l?   death?	
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 XYes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	th Check only one		
10	g Physie ter this neral di	n: To	27. Manner of Death	28a. Dale of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how it	e 6 □Other (Specifi njury occurred	<i>y)</i>
sior	Attending Indeath. actor: After by the funer	catio	1 Natural 5 Pending 2 Accident investigation	Victin	n of hous	se fire		
Division of	al or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate) (23 Chi	I Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	(Check only one)	iciam: To this best of my knowledge, dealer: On the basis of examination and/or i and manner stated.	nth occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause	aisi and mauner as si	tateu.  the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month,	
			> Light		OCME	Ар	oril 14, 20	JU4
	8		30. Name and address of person who co		111 Penn Street	. Baltimo	me. Marvil:	and 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	/	-, -u.c.iiii	TO, PICTYTO	MAG ZIZUI
14	Registr		APR 2 2 2004	Departura &	draw V			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $200\,\mathrm{Ly}$ 

12582

			1 - For State Registrar	Ciato or manytana /	Certific	ate of E	eath	Reg.	No.	1 5 0 0 2
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	Tippet	t			2. Date of Death Month	Day Year	3. Time of Death
	Examir	- 1	4a. Facility Name (If not institution, give s Howard Loid	street and number) My General 1	401p 46.0	City, Town, or	Location of Death	rbiei	4c. County of Death	ward
74 4	Funeral Director		5. Social Security Number 579-09-2853	7. Age (In yrs. last t M 2□F	yrs. If Ur Mont	nder 1 Year ths Days	Hours Min.	Date of Birth (Month, Day, Ye October 24	9. Birth <i>Cou</i> , 1917 V	place (Stete or Foreign ntry) Vashington DC
	Maryland a-f ahow iilied at	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland He	oward 10c. City, To	wn or Location		Columbia			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the	al Director	10e. Street and Number 5621 Tricross Dr.		10f.	. Zip Code	21045	10g.	Citizen of What Cou	ntry? S.A.
9036	d within 72 hours after death with the Maryland jiene. I than "natural", or Itams 23s or 28s-1 show the Medical Examinet must be tradified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? ★ 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		X	panic Origin? (Spec , Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Amen Black, White Specify:	
Maryland 21215-0036	TO 100 100 100 100 100 100 100 100 100 10	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondam (2-12)	cation 16 completed) College (1-4or 5+)	a. Decedent's L (Give kind of life. DO NO	Jsual Occupa f work done du T use retired)	tion tring most of working Baker	166	b. Kind of Business/Ir B	akery
land ?	be filed tal Hyg d other	To Be C	17. Father's Name (First, Middle, Last) Bradley Jo	oseph Tippett			18. Mother's Name (		den Sumame) /irginia Dean	
Mary			19a. Informant's Name/Relationship (Ty, Mr. Anthony Doyle	рө, Print) 19 Legal Guardian	b. Mailing Addi 1044	ress <i>(Street ar</i> 40 Little P	nd Number or Rural atuxent Parkv	Route Number, Ci /ay Columbia	ty or Town, State, Zi a, Maryland 21	044
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra QDCB.		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	demoval from State Cemet		or other place nation Ser	vices, Inc. <sup>04/2</sup>	21/2004	. Location - City or T Sykesvill	own, State e, Maryland
Bal	Depar Impor any in	1	2 Sign lure of Fundal Service License	lel moes 75	22. Name	Slack 1 3871 (	of Facility - uneral Home Old Columbia I	, P.A. Pike Ellicott (	City, MD 2104	3
	Pnysician /Medical Examiner		23a Part1. Enter the disease or complishock, or heart failure: List only or I mediate Cause (Final disease or condition esulting in death)	ications that caused the death. Do not cause on each line.  A  Due to (or as a consequence)	ute n	mode of dying	, 1	respiratory arrest,	tien	Approximate Interval Between Onset and Death
68760,	certificate be executed administration and burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	Sepe	tric	Mode	,		
	ertificate ling phy e as the	Medical	IF FEMALE:					***************************************		
.O. Box	death e atter	Physician/	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 ⊟Ectopi 5 ☐ Other	ic pregnancy (specify)			23d. Date of deliv Month	ery Day Year
rds, P	es De de	by	Part II. Other significant conditions con	ntributing to death but not resulting	in the underlyin	ng cause giver	n in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
of Vital Record	The law ate has b page 2 sl	Completed						24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of
Vita	sician certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2 ER/O	Outpatient 3	Othor	26. Place of Death (		- 50	
	ding h. After fune	ation; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		Time of Injury	28c. Injury Work	4   Nursing Home	d. Describe how in	6 □Other (Special Nigry occurred	y)
Division	al or Attenders after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, fac	ctory, office	28	f. Location (Street City or Town, St	and Number or Run ate)	al Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edical (	29a. Certifier 1 Certifying Physical Check only 2 Medical Exemination	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occur and/or investigat	red at the time tion, in my opi	e, date and place, an nion, death occurred	d due to the cause at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
)	To the lawithin 2. To the lacomplet	ž	29b. Signature and title of certifier	dim		29c. License	50870	29d.	Date signed (Month,	Day, Year) 1 2004
_	D		30. Name and address of person who co	empleted cause of death (Item 23a,	(Type, Print)	2 Ln.	Clark	isule	mD 8	11029
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 2 200	32. Registrar's Signature	& A	one	,			,

			For State	State of Marylan		nt of Health and te of Death		_ 211111.	12592
			State Registrar  1. Decedent's Name (First, Middle, La	et)	Certifica	le of Death	Reg. I	No. 2003	3. Time of Death
	Physici	an	CO O CO P.L. O C		lise	THENCE		Day Year 15 - 2004	: (1=0 MM
	/Medic Examin		4a. Facility Name (If not institution, give			y, Town, or Location of De		15 - 2004 4c. County of Death	7.20 11
	Examin	eı	4910 130	wland A	VP	Baltin	rore		
19	Funeral		5. Social Security Number 6. S	Sex / 7. Age (In yrs.	last birthday) If Und Month	er 1 Year   If Under 24 Hi	s. 8. Date of Birth	9. Birthp	place (State or Foreign
	Director		216-78-3892	1 M 2 BF	Yrs.	Days Hours IVII	6-18-	62	MD
	pue *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location			1	0d. Inside City Limits
	Aaryli sho	ŏ	M N		3a1+in	ACD			1 Yes 2 No
	the 28a-	Director	10e. Street and Number			lip Code	10g.	Citizen of What Coun	itry?
	3a of		4910 BOW.	land Ave		21200	0	U.5A.	
	in 72 hours after death with the Maryland "natural; or Itams 23e or 28e-f show ledical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was Dec	edent of Hispanic Origin? ecify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ameno Black, White,	
9	or Its		1 Never Married 2 Married	1 Tes 2 No		2 PNo Specify:		Specify: 2	LOCK
21215-0036	ural'.	d by	3 Widowed 4 Divorced	Year or Dates:	10- 0		100	101	1461
15	n 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Decedent's Us (Give kind of v life. DO, NOT	vork done during most of w	orking 166.	. Kind of Business/Inc	Justry
77	filed within I Hygiene. other then "rent, the Med	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		sable			
		Be C	17. Father's Name (First, Middle, Last	)			ame (First, Middle, Maid	len Sumame)	
Maryland		To B	Robert Jo	hnson		Mac	guer:	te Tu	15 Net
an	d 2 should th and Men 7 Is marke traumatic	i j	19a. Informant's Name/Relationship (	Type, Print) MOT &	19b. Mailing Addre	ss (Street and Number or I	7.7kg	y or Town, State, Zip	Code)
	s 1 and if Health itsm 27 other tr		Marguerite	TURNER	4191	Bowla		Bato. M	
ore			20a. Method of Disposition  1 Surial 2 Cremation 3	_	Place of Disposition (Nemetery, crematory of	ather placel		Location - City or To	
Baltimore,	tmen tant:		* 4 □ Donation 5 □ Other (Speci		MY. Car	, .		Sa 150.1	MD 2 1205
Bal	permit. Page Department of Important; If any Injury or		21. Signature of Funeral Service Lice	Theris fy.	22. Name W e.S	iey Chavis IE as Fer N	Ir. F.H. Ba	Ito .MD	21231
П			23a. Part1. Enter the dis a se or com shock, or heart failure. List only	plications that caused the death one cause on each line.	h. Do not enter the ma	ode of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	& END STAGE	CARDI	OMYOPATHY			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):				
Œ	(s)	7	Sequentially list conditions,	b. Due to (or as a conseq.	uanca of):				
7.1	nsit	Examine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury		,				
ď	sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
8760	death certificate be executed e attending physician and od for use as the burial-transit	dlcal		_ d			4-44-4		
9	ntifica ing ph s as th	Med	IF FEMALE:						
Вох	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	I death 3 ☐ Ectopic			23d. Date of delive Month	ny Day Year
0.	the a	Physiclan/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5 Other (	specify)			
<u>α</u>	requires that the de een signed by the a hould be detached	Ph	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
of Vital Records,	es be	d by		_		-	1 ☐ Yes	2 No 3 Prob	ably 4 □Unknown
00	w require	ompleted					24a. Was an	24b. Were autor	psy findings available
Re	The law ate has b page 2 sl	шо					autopsy performed 1 Yes 2	prior to condeath?	npletion of cause of
tai		C	25. Was case referred to medical			26. Place of D	1 ☐ Yes 2 ☑ I eath (Check only one)	10 165	20 140
<u>\</u>	ysic s ce direc	To B	examiner? 1 🗆 Yes 2 🖸 No	Hospital: 1   Inpatient 2	ER/Outpatient 3 [	Othor	Home 5 Residence	6 ☐Other (Specify	,)
0 0	ding Phy h. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred	
sio	Attanding ir death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be	20	М	1 ☐ Yes 2 ☐ No			
Division	2 = c	ertification:	4 Homicide determined		ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, Sta		Route Number,
	urs ara	O	29a. Certifying P	hysician: To the best of my kno	wledge death occurre	d at the time, date and plac	e and due to the cause	(s) and manner as st	ated
	To the Hosp within 24 ho To the Func completely f	edical	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	tion and/or investigation	on, in my opinion, death oc	curred at the time, date a	and place, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		2	9c. License number	29d. [	Date signed (Month, L	Day, Year)
)	^		> aurexam	MO		D16619	A	per 16,2	004
	18		30. Name and address of person who		n 23a) (Type, Print)	DIGGIA	E DA R	ALTHORE	MD 2123
	Sta	te	31. Date filed (Month, Day, Year)	32, Registrar's Signa	iture 🖋 🥒		11/2	/	
	Registr		APR 2 2 200		& spo	rks			

			1 - For State Registrar	State of Mary		epartme Certifica				Reg. No.	2004	12581
	Physici /Medi	cal	1. Decedent's Name (First, Middle, L	VE	ST	4h Cih	, Tourn or	Location of De	2. Date of Month	Day 20	Year 2604 County of Death	
	Examir	ier		SPITAL CE	NTER yrs. last birth	BA		MORE If Under 24	Hrs   0 Date of	Diah	O Blat	N/A
	Funeral Director		214-54-2578 Usual Residence of Decedent	1 <b>∆</b> M 2□F	57 Y	Months	Days	Hours N	fin. (Month, JUL ]	Day, Year) 13, 194	46 M	place (State or Foreign intry) aryland
	le Marylan Be-f show dilled at	ctor		Arundel	c. City, Town	I	Brook.	lyn				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the	Dire	10e. Street and Number 5019 Brookwood	Road		10f. Z	ip Code 21	1225		10g. Citiz	en of What Cou SA	intry?
036	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or liems 23a or 28e-f show event, the Medicul Evaira or must be recitled at	by Funeral Directo	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Tyes 2 2 No If Yes, Give Year or Dates:	r in U.S.	13. Was Dec If Yes, sp		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or uerto Rican, etc.)		4. Race - Amer Black, White Specify: Wh	, etc.
Maryland 21215-0036	within 72 ho ene. than "natur the Wedical	Completed	15. Decedent's l (Specify only highest g Elementary/Secondary (0-12)			Decedent's Us Give kind of w life. DO NOT LSable	rork done d use retired	turing most of	working		d of Business/la	ndustry
rland 2	should be filed within ad Mental Hygiene. marked other than 'matic event, the Me	To Be Co	17. Father's Name (First, Middle, Las Elvia Vest	ot)					Name (First, Midd Pauline	dle, Maiden S		
	: 1 and 2 s Health ar tam 27 is	2 d	19a. Informant's Name/Relationship Charles Salvino/ 20a. Method of Disposition 1 □ Burial 2 ♣ Cremation 3	brother-in-la	aW 80 20b. Place of E	024 010 Disposition (Na	Phi	ladelph	Rural Route Nur.	Rosec	lale, M	D 21237 Jown, State
Baltimore,	permit. Pages Department of I Important: If its any injury or o		*4 □ Donation 5 □ Other (Special Line)		Metro (				21/04 y of Mar ad Balt		Inc.	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or cos shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Saluentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SEPTI  Due to (or as a co	onsequence of onsequence of	t enter the mo	ode of dyin	g, such as card	ISEAS	arrest,		Approximate Interval Between Onset and Death  3 DAVS  DAVS  DAVS
, P.O. Box 68760,	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	d	regnancy Fetal death e of death	3 ☐Ectopic 5 ☐ Other (s	pregnancy specify)	•		-	d. Date of delive Month	ery Day Year he cause of death?
Records,	v requii	leted by							1 <b>24a.</b> W			bably 4 Unknown
	The ate h	e Completed	25 Was need referred to modical						- au pe 1 ☐ Yes	topsy rformed? 2 No	prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of
Division of Vital	ding Phys J. After this funeral dir	To B	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Ye	2 ER/Outp 28b. Tin		28c. Injury Work	er: 4 ☐ Nursin	g Home 5 Re 28d. Describ			(y)
Divis	<b>p</b> # # E	Certification:	3 Suicide 6 Could not 4 Homicide determine	be d 28e. Place of Injury - building, etc. (S	At home, farm	n, street, facto	ry, office			(Street and own, State)	Number or Run	al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	(Check only 2   Medical Exa	Physician: To the best of m aminer: On the basis of exa and manner stated.	amination and/	or investigatio	n, in my op	pinion, death o	ace, and due to the courred at the time	e, date and p	lace, and due t	o the cause(s)
)	To with	M	29b. Signature and title of certifier  Raj D. Pa	lepu MD			PES	000			signed (Month,	Day, Year)  2004
	Sta	ite	30. Name and address of person who RAT D. PAL 31. Date filed (Month, Day, Year) APR 2 2 2	EPU 30	001 5		OVER	37 B	ALTIMI	ORE	MO.	21225
	Regist		APR 2 2 7	2004   2004	A STATE OF	Cocale	B					

State of Maryland / Department of Health and Mental Hygiene 004 12585 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** APRIL 20, 2004 5:20a M Augusta Dean Way /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Joseph Richey Hospice Baltimore 8. Date of Birth (Month, Day, Year) APR 23, 1970 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Mir Yrs. Director 33 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Directo <u>Maryland</u> Baltimore Halethorpe 10f. Zip Code 21227 10g. Citizen of What Country? USA 10e. Street and Number 4012 McDowell Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 ☐ Widowed 4 🎇 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 Delivery Person Soda permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othe any injury or other traumatic avant, sone. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cecilia Hartman Frederick P. Way 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4012 McDowell Lane Halethorpe, MD 21227 19a. Informant's Name/Relationship (Type, Print) Frederick P. Way, Jr./brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 4/21/04 Baltimore, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Cremation softety of Maryland, Inc. Skome 299 Frederick Road Baltimore, MD 21228 Thomas Gregor Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) D. **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician at s the burial-t Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence Other (Specify) P 1 TYes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerai ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of completed cause of death (Item 23a) (Type, Print) St. Baltous 32 Registrar's Signature State Registrar

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	/Medio Examin	_	4a. Facility Name (If not institution, given 2805 Abilene I				4b. City, Town, Chevy	Chas	е			gomery
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	Maryland -f show	tor	10a. State 10b. County		10c. Cit	y, Town or Lo Washir	ngton, D	С				10d. Inside City Limits 1 XX es 2 □ No
	or 28a	Director	10e. Street and Number			-	10f. Zip Code				Citizen of What	·
36	72 hours after death with the Maryland Instural; or Items 23s or 28s-f show Insel Examiner must be nutilised at	by Funeral	5423 32nd Street  11. Marital Status  1 Never Married 2 Married 3 Widowed	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	es? 2 A No		200 Was Decedent of If Yes, specify Cu	Hispanic Ori Iban, Mexical				merican Indian, /hite, etc. white
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Maryland 2	should be filed withing the Mental Hygiene. marked other than matte event, it a M	To Be Co	17. Father's Name (First, Middle, Las  James Williams						er's Name <i>(First,</i> ary Weig		den Sumame)	-
Mary	and sum		19a. Informant's Name/Relationship Helen Pearson/Da				ng Address (Stree				·	e, <i>Zip Code)</i> 20815
Baltimore,	Pages 1 and 2 ent of Health nt: If item 27 i		20a. Method of Disposition  1 Burial 2 Cremation 3 1  4 Donation 5 Other (Speci	☐Removal from S	tate i	Place of Dispo cemetery, crea	esition (Name of matory or other po	(ace)	Date 4/21/04	20c	. Location - City	
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760,	ate be executed  Wedician and hysician and hybridal-transit	icai Examiner	26d. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	used the deat ch line. or as a consec or as a consec	quence of):		ying, such as		atory arrest,		Approximate Interval Between Onset and Death
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of Vital	ysicien: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	1-9-		ER/Outpatie	nt 3L DOA	Other: 4 No	e of Death (Checursing Home 5	Residence	o XXOther (S	Daughter's
Division (	ttending death. ctor: After / the fune	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	f Injury n, Day Year) of Injury - At h ng, etc. (Speci	28b. Time of Injury stome, farm, stome,	W	□Yes 2□	No 28f. Loc		t and Number o	Rural Route Number,
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	To th Within To th	Me	29b. Signature and title of certifier	m		$\sim$	29c. Lice	onse number	1891	29d.	Date signed (M	20,2004
	()		30. Name and address of person who	anShi	of death (Ite	98	Print)	eons	sia Y	trei	, Silve	or Spring
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death **Physician** Month Wilhelm Gordon 12:55 pm. April 19 2004 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8810 Walther Blvd. #3408 Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan. | Tan. | 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland Funeral Months 214-03-0295 86 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "neturel", or items 23a or 28e-f show ury or other treumetic event, I're Mcdcal Examinar mant be incitited at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd. #3408 21234 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Project Manager Mechanical Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Millard Wilhelm, Sr. Edna S. Hahn 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 8810 Walther Blvd. #3408 Baltimore, Md. 21234 Annette M. Wilhelm/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemtery 4-23-04 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease or complica ations that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, cause on each line. Approximate Physician Immediate Cause (Final disease or condition resulting in death) /Medical Colon cancer with metastases Examiner Physician/Medicai Examiner the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last is certificate hes been signed by the ettending physician end director, page 2 should be deteched for use as the bunel-trar Due to (or as a consequence of). Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown δ 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 2 No 1 Tes 1 □Yes 2 □ No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ို 1 Yes 2 No this 27. Manner of Death 28e. Dete of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident ofter death completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours e 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) mones 058646 M. D. 0, 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Parkville walther Boulevard MD 21234 Monius 8800 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State

Registrar

APR 2 2 2004

Saltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene200112588 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Day **Physician** 20, 2004 2:10 PM Richard Μ. Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year June 29, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 WV **Funeral** 1 X M 2 □ F Director 92 214-18-5656 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show empinjury or other treumetic event, the Medical Examiner must be nutfited at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Cockeysville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 International Cir. 21030 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced Year or Dates: 41 '~45' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 Accounting Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Harry S. Williams Lulu Thomasson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 International Cir. #335 Cockeysville, MD 21030 Gladys D. Williams/Wife 20b. Place of Disposition (Name of April 24, 20a. Method of Disposition 20c. Location - City or Town, State William Watters 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 2004 Jarrettsville, MD Cemetery 21. Signature of Funeral S. Dice Libens 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Road Timonium, MD 21093 Michael J. Flagle 23a. Part1. Solar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 266712 disease or condition resulting in death) 475 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification; To Be Completed by 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Accular disease performed? 1 Yes 2□ No 1 Yes 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑No funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death filled in by the 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

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completely filled 157 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) ules St. Balto . Md 6701 Rilsy Bon( 32. Registrar's gnature State Registrar

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Baltimore,			21. Signature of Juperal Service Ligens		22. Name and Add		MANO	VER, ME
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DHMH 16 Rev 6/95

		4	For State		State of Maryla	-		nt of Healt te of Dea			20	04	1.0	2500
_			Stete Registrar	intella Lance		Cer	lilica	le oi Dea	***************************************	2. Date of De		0 4	3 Time	of Death
	Physicia		1. Decedent's Name (First, M		(1) illiam	_				APRIL		Year	7:1	
	/Medic	al	SIUHKI		00111111	>	4h Cih	, Town, or Local	tion of Death		c. County o	f Death	111	
	Examin	er	4a. Facility Name (If not instit	Mon, give s	ICAL CENTE	O	4.14	APN is	ion or boat	,	ANNE	Λ	In Street	=1
7. X	<u> </u>		5. Social Security Number	6. Sex		rs. last birthday)			nder 24 Hrs.	8. Date of Bir	th	g. Birtho	lace (State	e or Foreign
	Funeral Director		124.20-1446	1 💆	M 2 F	4 Yrs.	Months	Days Hou	urs Min.	7-8-	39	Cour	SILV	ANIA
7,000			Usual Residence of Deceden											
	how		10a. State 10b. Co	A	1	City, Town or Lo	Do.					1		City Limits
	Se-fs	cto	MD ANA	EHR	UNDEL 5	EVERN	-	HRK						73 2 140
	or 26	Director	10e. Street and Number				10f. Z	ip Code	,		10g. Citizen of W	hat Cour	itry?	
	within 72 hours atter death with the Maryland ene. then "naturel", or items 23a or 28e-f show fre Modical Exercities must be notified at	Ta.	216 PINE A					21141	6		U.S.	H.	an Indian,	
	tems	Funeral	11. Marital Status		12. Was Decedent Ever in Armed Forces?	n U.S. 13.	was Dec If Yes, sp	edent of Hispani ecify Cuban, Me	xican, Puert	pecify Yes or No o Rican, etc.)	Black	, White,		
36	s afte	by F	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 😭 Divo		1 Yes 2 No If Yes, Give Year or Dates: 5 %	-50	1 🗆 Yes	2 No Spe	ecify:		Specify:	1.)	UTA	
2-0036	hour	edt		dent's Edu		16a. Dece	dent's Us	ual Occupation		la.	16b. Kind of Bus	iness/In	dustry	
215	n na	Completed	(Specify only h	ghest grad	College (1-4or 5+)			vork done during use retired)	most of wor	king		_		
212	iene iene	Eo	Elementary/Secondary (0-	12)	College (1-401 5+)	5	ALE	3			WATER	TRE	4TML	ENT
ğ	other	BeC	17. Father's Name (First, Mic		A 1 1			18. N	Aother's Nar	ne (First, Middle	. Maiden Sumame	)		
land	Aental Aental rked c	To E	STUART Ch	ARLE	SWILLIAM			EL	EANO	K DUFF	STAUF	FE	R_	
ary	2 should and Men is marks aumatic	i i	19a. Informant's Name/Rela		•	19b. Maili	ng Addre	The state of the s			er, City or Town, S	A	Code)	
>	and and m 27		JANE M. TAYLOR	2, F11	ance				ERNA		>-2114		- 01-1-	
ore	of H	1. 3	20a. Method of Disposition  1 Burial 2 Cremai	ion 3□F		b. Place of Dispo cemetery, cre-	matory of	ame or rother place)	. i	Date	20c. Location - C			
altimore,	Pages ment of tant: If it	1	`4 □Donation 5 □Oth	er (Specify)	2 _ B	AYVIEW	CRE	MATORY		9-04	BALTIMO	RE,	MD.	Þ
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28e-1 show amy injury or other traumatic event, the Medical Examinat must be notified at Once.		21. Signature of Full all Se	vice Lio	-0	2	2. Name Da	and Address of F ugherty Family	Facility / Funeral H	lome And Crei	mation Center, F	A.		
	00500		ANK	3/		D		2601 Mour	ntain Road	<ul> <li>Pasadena.</li> </ul>	MD. 21122		Approxim	nate
			23a. Part1. Enter the diseas shock, or heart failure.	List only of		1.	101 (110 111	ode or dying, suc	a cardia	or respiratory a	11051,		Interval E Onset an	Between
	Physician		Immediate Cause (Final disease or condition resulting in death)		Pheumo		5 1	neuma	mia					
*	/Medical Examiner		,		Due to (or as a con	-11		a) S4	-cut-					
		io io	Sequentially list conditions if any, leading to immediate	-	Due to (or as a con	-	1 03.3			,				
	t Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>~</b>	- Cancer	r Che	~o-	Heras	200					
Ć,	death certificate be executed e attending physician and of for use as the burial-transit	Exa	resulting in death) Last		Due to (or as a con	sequence of):			0		e,	1		
8760,	sicia ysicia e bur	cal			Adeno	corc	120	me c	of in	Jenowa	Prima	1	5.72	
9		ledi										<u> </u>		
Вох	h cer endir use	an/N	IF FEMALE: 23b. Was decedent pregnar	et	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I		□Ectopic	pregnancy			23d. Date Mon		ery Day	Year
0	deal	sicis	in the past 12 months?		4□Pregnant at time 9□Unknown		Other (				Mor	uri	Day	1941
P.O.	at the	Physician/Medical	9 🗆 Unknown			and the state of			O. all	ann Did	tobacco use contri	buta to t	20 021160 0	of deaths?
	law requires that the death certific as been signed by the attending p 2 should be detached for use as	b	Part II. Other significant co	naitions co	ntributing to death but not	resulting in the t	naenying	g cause given in i	Part I.			3 ☐ Prob		Unknown
orc	requi	Completed								-				
ec	2 8 2	nple								24a. Was	psy promed?	rior to co ath?	mpletion o	gs available of cause of
H	ate pag	Co								1 ☐ Yes	2 No 1		2 No	
of Vital Records,	Attending Physician: The r death. ector: After this certificate haby the funeral director, page	Be	25. Was case referred to me examiner?	-	Hospital:			Othor		ath (Check only				
ot	Phys this al diu	2	1 Yes 2 No		1 Inpatient	2 ER/Outpatie		28c. Injury at	☐ Nursing F		how injury occurre		y)	
uo	ding h. After fune	tion	1 ☑Natural 5 ☐ P	ending vestigation	28a. Date of Injury (Month, Day Yea	r) Injury	М	Work? 1 □ Yes	2 🗆 No		,			
Division	deat deat ctor: y the	fica	3 Suicide 6 □C	ould not be	28e. Place of Injury	At home, farm, st	reet, fact	ory, office			(Street and Numbe	r or Rura	i Route N	umber,
Ö	after after Dire	Certification:	4 Homicide		building, etc. (Sp	ecify)				City or 10	wn, State)			
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	a			sicien: To the best of my									n(a)
	n 24 l	ledical	one)		ner: On the basis of exar and manner stated.	mination and/or in	nvestigati	on, in my opinion	n, death occi	urred at the time				
	To the To the comp	ž	29b. Signature and title of c	entitle.			2	29c. License num	nber		29d. Date signed	(Month,	Day, Year	)
								NO02	0.57	/	4/16/09	+		
	5		30. Name and address of pe	rson who c	ompleted cause of death	(Item 23a) (Type	Print)	4.0000	1 Com	۵ ر صاد	4/16/09	e A.A.	2	
	- 2000		Howard	Naar!	Now Brown	2 Hound	el "	حورت	7 00		minerto II	2 10		
	St	ate	31. Date filed (Month, Bay,	004	32. Registrar's S	nignatere	sou	Es .						

DHMH 17 Rev 1/2001

Registrar

		- State Registrar		se Type or , 27 , 29ape State o		Cei	rtificate of	Death			Reg. N		J 7	1 6 (/
Physic	an	1. Decedent's Nan								2. Date of D Month MARCH		<sup>a</sup> 2004	Year	3. Time of Deat 8:17 A
/Medi	cal			Zuromski n, give street and no	umber)		4b. City, Town, o	or Location	of Death	PIARCH	- 1	c. County of	of Death	
Examii	ier	-		ouse Road			Baltim	ore				Ba1	timo	ore
Funeral Director		5. Social Security 219–18–5		6. Sex 1 🛣 M 2 🗆 F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Jan 26	ay, Year	r) 924		place (State or For ntry) vland
		Usual Residence			100.0	City, Town or Lo								10d. Inside City Lin
show	2	10a. State MD	10b. County	imore	100.0	Balti:								1 ∐ Yes 21√∑
28a-f	ecto	10e. Street and N		. Imore		Daiti	10f. Zip Code				10g. C	itizen of W	/hat Cou	ntry?
3a or	D			use Road				21220	)		_	JSA		
and Menial Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event. The Medical Examinar must be rediffed ut	by Funeral Director	11. Marital Status	rried 2∭XMar	12. Was De Armed F ried 1 XYes	2 No		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🖔 No	lispanic Or an, Mexica	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)		14. Race	k, White,	
ltural E E	ed b		15. Deceder	nt's Education		16a. Dece	dent's Usual Occup	pation			16b. I	Kind of Bus	siness/Ir	dustry
iene. • than "na the Madik	Completed	Elementary/Sec	cify only highe	st grade completed	(1-4or 5+) O	(Give	kind of work done DO NOT use retire salesper	during mos d)	st of work	ing		С	arpe	et
other other	BeC	17. Father's Name	(First, Middle,	Last)			*	1	er's Nam	e (First, Middle	e, Maide			
Menta rked tic ev	To B	Peter	A. Zu:	romski					Laur	a Tysol	kiew	icz		
and his ma		19a. Informant's					ng Address (Street				-			_
of Health item 27 other tr				i/spouse	l non		Wheelhou	ise Ko			-		2122	
Department of Health and Mer Important: if item 27 is marke any in ury or other traumatic once.			•	3 □Removal from Specify)	1		osition (Name of matory or other pla	ce)	-	Date	20c. l	Location - (	City or I	own, State
Depart Import any in once.		21. Signature of E	ulleral Service Ronald	S Wade	Direbts		2. Name and Addre tate Anat				. Ва	ltime	re S	Street
		1001	an	1/11	IL UE	l Ba	altimore,	MD	2120	1				
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ysician Medical		shock or he Immediate Cause disease or condit resulting in death	(Final	a. CHE	RONIC O	ath. Do not ent		ng, such as	cardiac	or respiratory	arrest,			Interval Between
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Il Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F Months -30 82 Yrs. 1691 Poland Director Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County NIA wode other traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director WD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21217 hen or Iteme 23a ec 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: à Whit 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within hand Mental Hygiene.
7 le marked other then "r College (1-4or 5+) Elementary/Secondary (0-12) ommercia nterior esigner 10 18. Mother's Name (First, Middle, Maiden Sumame) 37 K 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 le marked o any injury or other traumers. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14 East Read St. Patricia DY HO ' WIT Sparalmen Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4 ☐ Donation 21. Signature of Emeral Service Deer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Knd Stage arelmorascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) nding physician and use as the burial-transit The law requires that the death certificate be executed Due to (pr is a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 Yes 1 ☐ Yes eri 00 To the Hospitel or Attending Physicien: 25. Was case eferred to examiner? the funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely one) and manner stated 29d. Date signed (Month, Day, Year) Signature and utle of certifier 29c. License number 29b 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100

State

Registrar

31. Date filed (Month, Pay, Year)

APR 2 3 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

						Cert	ificate of	Death		Reg. No	201	7 la	12503	)
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	Physicia /Medic	-	Harrie David	Ballou					Apri		9,200		1:15 AM	[
	Examine		4a Facility Name (If not institution, giva	street and number)				4b. City, Town, o	Location of Dea	th 4c	. County o	of Death		
			Cherry Lane Nurs	ing Home				Laurel		P	rince	e Geo	orge's	
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Maryland 21215-0036			3 Widowad 4 Divorced	If Yes, Give Yaar or Dates:		10	☐ Yes 2 X No	Specify:			Specify:	B1a	ick	
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ary	Should No		19a. informant's Nama/Ralationship (T)	ype, Print)		19b. Mailing	Address (Stree	and Number or F	Rural Routa Numi	ber, City	or Town, S	Stete, Zip	Coda)	
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ORIGINAL

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death 3. Time of Death P Decedent's Neme (First, Middle, Last) 2. Date of Death Physician 00 /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9 timore OWn Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 21 F Days 213-44-0878 Months Hours Min. Director 449 Irainia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "naturel; or flams 23s or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at Maryland t Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 □ Divorced Specify: Year or Dates slac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worke eteria 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) (daugnter) 812 orton a Md. a lyonne Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation ö 3 Removal from State ike Church Com permit. Page Department of Important: If any injury or 12004 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilities of Republic R 21. Signature of Funeral Service License Hame 21216 W. North Ave. Funeral Home Jose 23a. Part I Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ung /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Ulease or in the initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
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9 Unknown detached for Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1ДYes 2□No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) this 27. Manger of D ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Jescribe how injury occurred After 1 Natural Injury 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certiful 29c. License number 29d. Date signed (Month, Day, Year) 2 10.1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rini Pana IY m 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 3 2004 Registrar

		1 - State Registrar  1. Decedent's Name (First, Middle, Last,	State of Marylar	•	tificate of l			19. No. 200	3. Time of Death
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Funeral Director		5. Social Security Number 6. Sec 220–38–8890	y   α η α   7. Age (In yrs   M 2   ΣΥ   F	. last birthday) 61 Yrs.	Baltimo If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. 8i	NA rthplace (State or Fore country) MD
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Department of Heelth and Important: If Item 27 is my any injury or other treum once.		MAE B. NEWSOME (  20a. Method of Disposition  1 \( \text{M} \) Burial 2 \( \text{Cremation} \) 3 \( \text{F} \)  4 \( \text{Donation} \) 5 \( \text{Other} \) (Specify)  21. Signature of Funeral Service Licens	SISTER)  demoval from State  V	520 Place of Dispo cometery, crea OSHELL	8 KELWAY sition (Name of natory or other place CEMETERY . Name and Addres	RUAD I	BALTIMORE, Date 2	MD 2123 Oc. Location - City of BALTIMORE, JERAL HOME	Town, State M2
nysician Medical Medical Kaminer	Examiner	23a. Pan1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that indiated events resulting in death) Last	Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect	th. Do not ent quence of):	or the mode of dying	NOR STRE	CET RALTI	MORE, MD	21217 Approximate Interval Between Onset and Death
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n	1	30. Name and address of person who co		-		MD			

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1	Funeral			Sex 7	'. Age (In yrs		y) If Under Months	1 Year Days	If Under 24 H	Irs. 8. Date of Bi	rth ay, Year)	9. Bir	thplace (State or Foreign ountry)
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	yland		10a. State 10b. County		10c. C	ity, Town or	Location						10d. Inside City Limits
	e Mar	ctor	MD Howard		Co.	lumbia							1 Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip	Code			10g. Citiz	zen of What Co	ountry?
	s 23e		6336 Cedar Lane	10 Was Dass	took Even in I	10 4			21044	/0	1.	USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23e or 28a-f show other treumatic event, the Madical Examinet must be notified at	by Funerai	Narital Status     Never Married 2  Married     Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tes If Yes, Give Year or Da	ces? 2. <b></b> o	J.S. 13	If Yes, spec	ify Cuban	Specify:	(Specify Yes or No lerto Rican, etc.)		14. Race - Ame Black, Whit Specify:	
21215-0036	2 hou atura	ted	15. Decedent's I	Education			edent's Usua				16b. Kir	nd of Business	
215	thin 7. 8. 8n °n	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-	4or 5+)	(Gi life	e kind of wor DO NOT us	rk done du se retired)	iring most of	working			-
7	ed wil	Соп	12			Hom	emaker					vn Home	
Maryland	tal H d off	Be	17. Father's Name (First, Middle, Las							Name (First, Middle	•	Sumame)	
Ž	hould I d Meni marke matic	ဥ	Henry C. Krause  19a. Informant's Name/Relationship			19h Ma	ling Address	/Street ar		Rural Route Numb		Town State	Zin Code)
<u>B</u>	nd 2 sho lith and 27 is m		Grover Bradley,		on	1	_			n, Columb			. –
<u>6</u>	is 1 and 2 of Health a item 27 is other treu		20a. Method of Disposition		20b.	Place of Dis	position (Name	ne of		Date		cation - City or	
Ë	Page: nent o int: If		1 ☐ Burial 2 【XCremation 3 • 4 ☐ Donation 5 ☐ Other (Spec		tate Ba		ce Wash		1	/24/04	L	aurel,	MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Fundal Service Lice	ensee	à	G	ary L.	Kau:	of Facility fman Fi	uneral Ho	me@Me	eadowri	dgeMem. Pk.
	<u></u>		23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that ca	used the dea	th. Do not e	nter the mode	of dying,	such as card	LVd., Elk fiac or respiratory a	rrest,	3, IVIL)	Approximate Interval Between
2	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	in Gi	STIV	3 1-	EAR	TF	Alwas			Onset and Death 4 webses
	Examiner			Due to (c	r as a conse	quence of):	CIAN	0,5	mes	PATUY			5 yrings
٠,	<b>%</b>	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	r as a conse					7. 00			3 70. 103
	rcuted nd transi	Examiner	Cause (Disease or injury that initiated events	c									
90,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (c	r as a conse	quence of):							
8760,	physic	dicai		d									
9 X	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregr	ancy		-			2	3d. Date of del	iven
Box	death e attei d for u	iciar	in the past 12 months?	4□Pregna	th 2 Fet nt at time of		☐Ectopic pre☐ Other (spe				-	Month	Day Year
P. 0	at the de by the a tached	hys	9 🗌 Unknown	9□ Unknov									
	res tha igned I be det	by	Part II. Other significant conditions		ath but not re	sulting in the	underlying ca	use giver	in Part I.			-	the cause of death?
ord	w requir been si should I	eted	SEPSIG							_ 10	Yes 2.2∑	No 3 □ Pr	obably 4 Unknown
Vital Records,	e law has b	Completed								24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of
a			Uhnrang T	MAST 1	NREG	run				1 ☐ Yes	2 200	1 🗆 Yes	2 No
	sicia s certi lirecto	To Be	25. Was case referred to medical examiner?  1 Yes 27 No	Hospital: 10010	patient 2	TER/Outpat	ent 3□ DO	Other		Death <i>Check</i> only on the control of		CO** (0	
10	£ = =		27. Manner of Death	28a. Date of		28b. Time		Bc. Injury a Work?		28d. Describe			ary)
Ö	andin lath. or: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati	on	, Day 1 tall	Injury	М		s 2 No				
Division of	of or Attending Fafter death.  I Director: Aftered in by the funeral	Certification:	3 Suicide 6 Could not 4 Homicide determine	4 280. Flace	of Injury - At h g, etc. (Spec	nome, farm, .	street, factory,	, office		28f. Location ( City or To		Number or Ru	ral Route Number,
	pitel	Ce	29a, Certifier TRI Certifying F	Physicians To the	nost of my kn	owledge de	**						
	To the Hospitel or within 24 hours after To the Funeral Direction completely filled in the filled in	edicai		eminer: On the bas and manne	sis of examin	ation and/or	investigation.	in my opii	nion, death or	ice, and due to the courred at the time,	date and	and manner as place, and due	to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier					License				signed (Month	-
			1 Lanell	yang	~			) 36	974		04	120/2	204
	10		30. Name and address of person who	completed cause	of death (Ite		e, Print)	المحترمة	1 TM 83	acur c	SUN	~14 i	vn 21344
	Sta		31. Date filed (Month, Day, Year)		gistrar's Sign	ature	Sport	1.					
	Registr	ar	APR 2 3 2004	A server		py ,	good	2/					

			1 - For State Registrar	5	tate of M	aryland	/ Depa	artment of F <i>tificate of</i>	lealth and l <i>Death</i>		giene 2 () Reg. No.	104	12597
	Physici	200	1. Decedent's Name (First, Mic	dle, Last)						2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic		Jacquely	า		L.	Ba	rham				004	6:53a M
	Examir	er	4a. Facility Name (If not institut	-		1		4b. City, Town, o	r Location of Death	)	4c. County	of Death	
			Union Mem. H			// /	4 6 1-46 -4- 1	Balti If Under 1 Year	More If Under 24 Hrs.	10.5.	N.		
	Funeral Director		5. Social Security Number	6. Sex 1 ☐ M	3FTF	ge (In yrs. last	Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day	, Year)		lace (State or Foreign try)
			219-40-9668 Usual Residence of Decedent		Λ	81				9-4-22	2	R.I	•
	yland		10a, State 10b. Cour	ty		10c. City, T	own or Lo	cation				1	Od. Inside City Limits
	Mar 9-f st	ţċ	Md.	AV		В	altim	ore					t <b>X</b> Yes 2 ☐ No
	or 28.	Director	10e. Street and Number			-		10f. Zip Code			10g. Citizen of \	What Coun	try?
	23e c	a	809 N. Benta	lon St.				212	16		USA		
	ems ems	Funeral	11. Marital Status	12.1	Was Decedent Armed Forces?	Ever in U.S.	13.	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Rac	e - Americ	an Indian,
36	or It	J.	1 Never Married 2 M	arried 1	I ☐ Yes 2 🔯 If Yes, Give Year or Dates:			I □ Yes 2 ☑ No	Specify:	7.1.54.1, 516.1,	Specify		
ö	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-1 show the Medical Examinat roust be notified at	Completed by	3 ₩ Widowed 4 Divorc										ack ——————
<del>7</del>	n 72	ete	(Specify only high		mpleted)	1	(Give	lent's Usual Occup kind of work done OO NOT use retired	ation during most of worl d)	king	16b. Kind of Bi	usiness/Inc	lustry
12	filed withi Hygiene. rthar then ant, the M	ᇤ	Elementary/Secondary (0-12		College (1-4or :	5+)					Total	. 1 5	
פ	filled Hygir othar ant,	BeC	12th grade 17. Father's Name (First, Midd	e, Last)	rs.		AĻ	ditorine	18. Mother's Nam	ne (First, Middle,	Interr		evenue
Maryland 21215-0036	2 should be and Mental is marked or reumetic ave	To B	Walter	s.			Hall		Ethel		Fa	Maru	eather
ar <sub>Z</sub>	shou and N s mar		19a. Informant's Name/Relatio	nship <i>(Type, i</i>	Print)			g Address (Street	and Number or Ru				
	1 and 2 Health a tem 27 is		Karen Miller	I	aughtei	r	11	Big Stone	e Court,	Baltimor	e. Md.	212	28
ore.	of He of He fitem r oth		20a. Method of Disposition 1 → Burial 2 □ Crematio	2 🗆 Domo	wal from State		e of Dispo	sition (Name of natory or other place			20c. Location -		
altimore,	Pages nent of I ant; If its ary or o		`4 Donation 5 Dother	n 3 ∐Hemo (Specify)	val from State			. Pk.		6-04	Randa]	llsto	vn, Md.
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumetic avent, the Medical Examinat rust be notified at ORGs.		21. Signature of uneral Service	e Licensee				Name and Addre	•		ltimore		
			23a, Part1, Enter the disease.	or complication	ons that caused	the death. [					E. Nort	n Ave	Approximate
			23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final	st only one ca	use on each li								Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Due to (or as	no	70	scien	otic clar	CAC	w-		Hour
П	Examiner				Due to (or as	a consequen	ce or):	PSCC	lar	diser	1200		
		ě	Sequentially list conditions, if any, leading to immediate	b	Due to (or as	à consequet	ce of).						<del></del>
	cuted Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b> .									
Ó	e exe lan ar urial-t	EX	resulting in death) Last		Due to (or as	a consequen	ce of):						
68760	ificate be executed g physician and as the burial-transit	edical		d									
-	= D 0	Med	IF FEMALE:			-				-			
Вох	attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	- 1	f yes, outcome I □Live birth	2 Fetal de	ath 3□	Ectopic pregnancy			23d. Dat Mor	e of deliver	y Day Year
	The law requires that the death cert lite has been signed by the attending page 2 should be detached for use a	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown		1□Pregnant at 9□Unknown	t time of death	າ 5∟	Other (specify)			10101		Jay Toal
a.	that the	P	Part II. Other significant cond	tions contribu	itina-to death b	ut not resultin	a in the ur	derlying cause gry	en in Part I	23e Did toi	acco use contr	ribute to the	a cause of death?
Vital Records,	sign d be	d by	Drofo	und	Der	nen	tin	secon	rlan	1 □ Y€			ibly 4 □Unknown
Ö	v requ	Completed	700 /	1/26	o vine	ico D	150	ATO A	d	24. 115			
ĕ	has ge 2	m m	- IV A	1	1	1 1	(30	736 777	00-0	24a. Was a autops perforr	y p	vere autop rior to com leath?	sy findings available pletion of cause of
<u></u>	n: Th ficate or, pa		SUB	HV AC	nnoi	a ne	emo	rrnag	<u> </u>	1 ☐ Yes 2	No 1		2□ No
5	Physician: The lav this certificate has al director, page 2	o Be	25. Was case referred to medie examiner? 1 ★ Yes 2 No	Hospi	tal: 1 □ Inpatie		Outestion	3□ DOA Oth	26. Place of Deat er:	1 1 1		10 11	
ō	g Phy ar this aral d	$\vdash$	27. Manner of Death	28	Ba. Date of Inju (Month, Da		b. Time of	28c. Injun	4 A Nursing Ac	me 5 Reside			
0	nding ath. :: Afte e fun	ţ	1 Natural 5 ☐ Pend 2 ☐ Accident inve	ting tigation	(Month, Da)	y Year)	Injury		(? Yes 2 □ No		•		
Division of	Atta er de recto by th	Certification:	3 Suicide 6 Coul 4 Homicide dete	d not be mined 28	Be. Place of Injude	ury - At home	, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and Number	er or Rural	Route Number,
Ξ	ital or irs aftr ral Dir led in	Cer		t je	building, on	c. (opecny)				- Chy of Town	, State)		
	To the Hospital or Attanding Physician: within 24 hours after deals as after deals To the Funaral Director: After this certifics completely filled in by the funeral director; p	Medical	29a. Certifier 1 ☐ Certify (Check only one) 2 ☐ Medic	el Exeminer:	n: To the best of On the basis of and manner sta	f examination	dge, death and/or inv	occurred at the timestigation, in my of	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and mai ate and place, a	nner as sta and due to	ted. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certification	ier	1	7		29c. License			9d. Date signed		
			M. An	Thomas	12l	u L	w	Da	5205		Gor, 2	21,	2008
	n		30. Name and address of person	n who oppiple	eted cause of	eath (Item 23	а) (Туре, І	Print)	0 0	0	<del>U</del>		7 10
			W.A.R.	ley	6-37	nc 6	701	N. Cl	rules.	It. Ba	lto n	ed c	-1208
	Sta Registr		31. Date filed (Month, Day, Yea		32 Registra	ar's Signature	Soo	de)					

			1 - State Registrar	State of	Maryland		artment of H		Mental Hyg	iene 2 (	004	12598
	Physici /Medi		Decedent's Name (First, Middle, Las     Horace Biederma						2. Date of Dea Month April		2004	3. Time of Death 4:00A M
	Examir		4a. Fecility Name (If not institution, give 623 Brisbane Ro		iber)		4b. City, Town, or Balti		ith	4c. County	of Death	
ŀ	Funeral Director		5. Social Security Number  217-14-0047  Usual Residence of Decedent	x XM 2□F	7. Age (In yrs. Ias 87	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year)	9. Birthpl Count Mary	
	h the Maryland or 28a-f ahow on attified at	Director	10a. State 10b. County  Maryland  10e. Street and Number			Town or Lo			1	0g. Citizen of		0d. Inside City Limits 1   Yes 2  No  No
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23s or 28s-f ahow other traumatic event, the Medical Examinat must be notified at	by Funeral	623 Brisbane Roa  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced		2 ∰No ∍	'	2122  Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (	Specify Yes or No- nto Rican, etc.)	Bla	A.  ce - America ck, White, e	etc.
Maryland 21215-0036	filed within 72 hc Hygiene. ther than "naturent, the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-	4or 5+)	(Give life. L	lent's Usual Occupa kind of work done of DO NOT use retired, Driver	uring most of wo	orking ame (First, Middle, M	Stee1	usiness/Ind	
arylan	2 should be and Mentai ls marked o	To Be	Louis Biedermann  19a. Informant's Name/Relationship (7)	ype, Print)		19b. Mailin	g Address (Street a	Mary	C. Bass			Code)
altimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 li any injury or other tra once.		Frances Biederman  20a. Method of Disposition  1 Disposition  2 Cremation 3 Disposition  4 Donation 5 Other (Specify  21. Signature of Fundamental Service Center)	Removal from S	20b. Plac	e of Disponeratory, crem	sition (Name of natory or other place	4-2		20c. Location	City or Tov	wn, State
	Prysician /Medical Examiner	10	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	a. Due to (c	used the death. ch fine.	Do not ente	30 Edmond	ison Ave	nue Cator	est,	, Mar	yland 2122 Approximate Interval Between Onset and Death
x 68760,	death certificate be executed e attending physicien and of for use as the burial-transit	/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (d	or as a consequer	nce of):	Ark	lat	ton Disea —			
.O. Box	at the death by the atten tached for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live bir	th 2 🗌 Fetal de nt at time of deat	ath 3 🗆	Ectopic pregnancy Other (specify)			Mo	te of deliver nth [	y Day Year
Records, P	The law requires that the te has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions co	ntributing to dea	ath but not resulting	ng in the un	derlying cause give	n in Part I.		acco use cont s 2 \( \sum \) No	ribute to the 3 □ Proba	cause of death?
		Completed	(/1)							ned?	Were autoportion to compleath?	sy findings available pletion of cause of
Division of Vital	ng Phys fter this ineral di	Certification; To Be	27. Manner of D ath   Natural 5   Pending     Accident   investigation	28a. Date of		VOutpatient Bb. Time of Injury	28c. Injury Work	T 4 □ Nursing H	ath (Check only one dome A Reside 28d. Describe ho	nce 6 Oth		
N N	pital or Att ours after d lerel Direct filled in by t		3 Suicide 4 Homicide 6 Could not be determined	1201	of Injury - At home g, etc. (Specify)			data and place	28f. Location (Str City or Town,	State)		
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only one)  29b. Signature and title of certifier	ner: On the bas	sis of examination	and/or inv	estigation, in my op	nion, death occi		use(s) and ma te and place, a ld. Date signed	and due to t	he cause(s)
1/2	Sta	te	30. Name and address of person who co	Hun	of death (Item 23	ice		RADH	A R6	DO	4.0	7 2120 I
	Registr	ar	APR 2 3 2004	Sente	ma B		Carl.					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Unpend Item #23a, 27,28a fr per ine	Cei	tificate o	Health and M f Death	lental Hyg	giene 10g. No 2004	12599
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
	/Medi	-	RONALD D	BIE	DERMAN		APRIL 2		18:03 M
	Examir	ier	4a. Facility Name (If not institution, give street and number)  11 SUNTOP COURT APARTMENT 102			, or Location of Death		4c. County of Deat BALTIMORE	h
N	F		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Yea		8 Date of Birth		hnlang (State or English
35	Funeral Director		216-52-5467	Yrs.	Months Day		8. Date of Birth (Month, Day, MAY 1,		hplace (State or Foreign untry) YLAND
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23a or 28a-f show whit the Medical Exam we must be notified at		10a. State 10b. County 10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	the Marylar 28a-f show	ctor	MD BALTIMORE	PIKES	SVILLE				1 ☐ Yes 2√ No
	or 28	Funeral Director	10e. Street and Number		10f. Zip Code	)	1	0g. Citizen of What Co	untry?
	ath w	rail	11 SUNTOP CT., UNIT 102		21209			USA	
	Items :	une	11. Marital Status  12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Was Decedent of Yes, specify Cu	f Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give X 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		I⊡Yes 21XIN	lo Specify:		Specify: W	HITE
P	72 hours aft "natural", or edical Exami		15. Decedent's Education	16a, Decec	ient's Usuai Occ	supation		16b. Kind of Business/	Industry
215	hin 72	plet	(Specify only highest grade completed)	(Give	kind of work dor OO NOT use reti	ne during most of work	ing	Too. Talla of Dasilloss	maasiy
21	d with	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		TEACHER	2		SPECIAL EDU	JCATION
pu	be file ntal Hy nd oth avent	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Sumame)	
yla	2 should be filed withir and Mental Hygiene. Is markad other than 'aumatic avent, 'he M	၉	SOL BIEDI	ERMAN		YETTA			DWSEND
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Itam 27 Is markad other than "natural", or Items 23a or 28a-f shov other traumatic avent. The Medical Exam. or invest to collified at	10	19a. Informant's Name/Relationship (Type, Print)					, City or Town, State, Z	
6,	ges 1 and 2 t of Health If itam 27 or other tra		ELLEN BIEDERMAN (WIFE)		SUNTOP C sition (Name of	T., UNIT 1		KESVILLE, M	
Baltimore,	0 0		1 Burial 2 Cremation 3 Removal from State	emetery, crem	natory`or other p	lace)		20c. Location - City or	
臣	urtmer urtant njury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Fyheral Service Licepses		AHAVAS		22/04		OWN, MD
Ba	permit, Pag Department Important: I any injury o		Septiminal Style Library Control Control					ON & BROS.,	
			23a. Part1. Enter the disease, or complications that caused the death	h Do not onte		des englished and all of		IKESVILLE,	Approximate
	Physician /Medical Examiner		shock, or heart failure. List only one make a prochime to the death shock, or heart failure. List only one make a prochime (zol) immediate Cause (Final disease or condition resulting in death)  List only one make a prochime (zol) into (zol) i	uence of):	xycodone,	tramadol, ar	nd Diphenh	ydramine)	Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	dicai Examiner	The total and the constant of						
P.O. Box 68	death certific e attending p d for use as	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3	Ectopic pregnan Other (specify)	icy		23d. Date of deliment	very Day Year
	w requires that been signed b should be det	by	Part II. Other significant conditions contributing to death but not rest	ulting in the un	derlying cause g	given in Part I.		acco use contribute to	V
Vital Records,	The la ate has page 2	Completed					24a. Was ar autopsy perform 1 \( \text{Yes} \) 2	24b. Were aut prior to co death? No 1 \(\sum Yes\)	opsy findings available ompletion of cause of
Z.	Physician: This certificated director, p	Be	25. Was case referred to medical examiner?  Hospital: Hospital:			26. Place of Death			200
of	ding Phys h. After this funeral dir	on: To	1 Yes 2 No  Hospital: 1 Inpatient 2   27. Manner of Death 1 Natural 5 Pending investigation investigation	ER/Outpatient 28b. Time of Injury	Zec. inj	ork?	me 5 Resider 28d. Describe hor	nce 6 7 Other (Spec w injury occurred	VAT SCENE
S.		cati	2 Accident investigation 4/20/04	اللنوار				gested pills	
Division	or Al after of Direction by	Certification:	Homicide determined 288. Place of injury - At no building, etc. (Specify		et, factory, office	9	28f. Location (Str. City or Town,	eet and Number or Rui State) II Sunto	p Court
J	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edicai Ce	29a. Certifier (Check only cond)  29 Medical Examiner: On the basis of examinat	wledge, death	occurred at the estigation, in my	time, date and place, a	Pikesville and due to the called at the time, da	use(s) and manner as	stated,
	To the twithin 2. To the I complet	Med	one) and manner stated.  29b. Signature and title of certifier			nse number			
	<u> </u>		Patrui aronice-to	sllve	0	CME		Id. Date signed (Month, APRIL 21, 20	
			30 Name and address of person who completed cause of teath (Item 31. Date filod (Month, Day, Year)  32. Registrar's Signal	ak MI		nn Street,	Baltimo	ore, Maryla	nd 21201
	Sta Registr		31. Date filod (Month, Day, Year) 82. Registrar's Signal APR 2 3 2004	Goes					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

				1 - For State Registrar		State o	f Maryla		epartmer Pertifica			nd Ment		ene g. No. 2	004	1260	
		Physic /Medi Exami	cal	1. Decedent's Name Richa 4a. Fecility Name (#	ard Wils	on Cleme			4b. City	, Town, or	Location of	Ap	ate of Death Ionth ril 2]	Day 200	Year 4 y of Deeth	3. Time of Death	М
		Funeral Director		Carroll 5. Social Security No. 229-30	-7544	General Sex 12M 2DF	Hospit 7. Age (In y	rs. last birtho	Months	wings riyear Days	Mills If Under 2 Hours	Min. (A	ate of Birth fonth, Day,	Bal <sup>.</sup> (ear) 1929		e place (State or Forei ginia	gn
E		h the Maryland or 28e-f ehow	tor	Usual Residence of 10a. State	10b. County  Baltimo	ore		City, Town o	r Location Mills							10d. Inside City Limit	
EMENT		ath with the s 23a or 286	ral Director			Court, A				21117				g. Citizen of USA	What Coul	ntry?	
372	5-0036	72 hours after death with the Maryland natural', or items 23a or 28e-1 show disal Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed	ed 2 Married 4 Divorced	12. Was Dece Armed Fo 1 XYes If Yes, Giv Year or D	rces? 2∐No ⁄e ∆	rmy	13. Was Dece If Yes, spe 1  Yes		spanic Origii n, Mexican, i Specify:	n? (Specify Y Puerto Rican	es or No- , etc.)		ce - Americ ck, White, 'y: W		
W. C	21215-0	드 - 등	Completed	(Special Special 15. Decedent's ify only highest g ndary (0-12)		-4or 5+)	(G lif	ecedent's Usu live kind of wo fe. DO NOT u	ork done d ise retired)	luring most o	of working	16	Sb. Kind of B			-	
7 <		be filed stal Hyg od othe event,	To Be Co	17. Father's Name (				_   _ n	ome Im	•	18. Mother's	s Name (Firs ie Ann				yea	
1CHA2D	altimore, Maryland	permit. Pages 1 and 2 should Department of Health and Mer Importent: If Item 27 is marks any injury or other traumatic once.		19a. Informant's Na  Michele ( 20a. Method of Disp 1   Burial 2   ' 4 □ Donation	Clements osition    Cremation 3	- daugh	State 20b	11 W	alling Address estmin sposition (Nai crematory or d idge M	ster me of other place	Rd.,	Apt. 2	, Reis	-	OWN . City or To	MD 21136 own, State	
Q	Balti	permit. Departn Importe any inju		21. Signature of Fur	Pople				22. Name ar Gary L 7250 W	. Kau	ıfman Igton	Funera Blvd.,	l Home Elkri	e @ Mea Lage,	dowri	dge MP Inc 1075	•
		Physician /Medical		23a. Part1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	t Mailure. List oni Final	y one cause on e	tcu	eath. Do not sequence of):	Resp		, such as ca		luc			Approximate Interval Between Onset and Death	
	8760,	exacuted be executed by sician and sthe burial-transit	dical Examiner	fequentially list confianty, leading to imcause. Enter Under Cause (Disease or ithat initiated events resulting in death) L	njury	c.	or as a cons	equence of):  1. F.	mg								
	P.O. Box 68	ath certif	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1  Yes 2  Unknown	months?		irth 2 □ Fe ant at time o	etal death	3 ⊡Ectopic pi 5 ⊡ Other <i>(sp</i>						te of delive	ry Day Year	
		vrequires that the de been signed by the a should be detached f	by	Part II. Other signific	cant conditions	contributing to de	ath but not r	esulting in the	e underlying c	ause giver	n in Part I.					e cause of death?	1
	al Reco	ilcien: The law ri certificate has be rector, page 2 sho	Completed		o f	fnae	mis					-	ta. Was an autopsy performe Yes 2	d?   {	Were autor prior to con death?	osy findings available npletion of cause of	,
	Division of Vital Records,	ng Phys tter this meral di	Certification; To Be	25. Was case referred examiner?  1 Yes 2 2  27. Manner of Death  1 Natural  2 Accident	5 Pending investigation	28a. Date of (Monta	of Injury h, Day Year)		of 2 y M	Other Other Pac. Injury: Work?	<sup>©</sup> 4 □ Nursii at		-			()	
B	Divi	spitel or Att ours after d neral Direct filled in by	al Certif	3 ☐ Suicide 4 ☐ Homicide  29a. Certifier	determined	28e. Place buildin	ig, etc. (Spe	nowledge de	street, factory	at the time	date and n	Vace, and du	y or Town, S	State)	noor as at	Route Number,	
	<b>.</b>	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical	(Check only one) 29b. Signature and t	Ne of certifier	miner: On the ba	sis of exami er stated.	nation and/or	29c Print) 7 Ma	in my opi	nion, death o	occurred at th	e time, date	Date signed	and due to	the cause(s)	
		UX1	and the state of t	30. Name and addre	ss of person who	D 11	of death (It	em 23a) (Typ	De, Print)	l cali	y da	ure 1	West	y-Z,	1-0 1-0	<u>y</u>	_
	ľ	Sta Registr	-	31. Date filed (Mont/			gistrar's Sig	of ture	oaks	/							_

			State of Maryland / Department of Health and M 1- For Amend Item 23a per Dr., 0830, 04/23/04, dhb Certificate of Death	lental Hygie	ne 2004	12601
			1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physici: /Medic		Hniyah J. Cage	Month		11:50AM
,	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  3367 Porring Manor Rd.  BALTIMORE		4c. County of Death	
	Funeral		5 Social Security Number 6 Sax 7 Age (In vrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthpl	ace (State or Foreign
	Director		212-69-6067 Days Hours Min.  Usual Residence of Decedent	12-20-2	003 MA	RYLAND
	yland now		10a. State 10b. County 10c. City, Town or Location		10	Od. Inside City Limits
	se Mar	Director	MD BALTIMORE			1 1 Yes 2 □ No
	with the	Dir	2367 Perring Manor Rd. 21234	10g.	Citizen of What Coun	try?
	death	Funerai	11. Marital Staffis 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Society)	ecity Yes or No-	14. Race - America Black, White, e	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23e or 28a-f show or other treumatic event, the Mudical Evantimer must be multified at	by Fu	Amed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  Amed Forces?  1 Yes, specify Cuban, Mexican, Puerto  1 Yes, Sive  1 Yes, Sive  1 Yes 2 No Specify:  Year or Dates:	r ricarr, cro.,	Specify: R	a. k
21215-0036	2 hour		15. Decedent's Education 16a. Decedent's Usual Occupation	16b	. Kind of Business/Ind	ustry
2	ne. hen "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)	ng	1/ 1/	
q 7	Hygie Hygie other t		17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, Maid	den Sumame)	
<u>/lan</u>	louid be filed I Mental Hygi Parked other natic event. I	To Be	Kori L. Cage Malik	la N.	Coppe	dge.
Maryland	and I		19a. I pormant's Name/Relationship (Type, Friot)  19b. Mailing Address (Street and Number or Rura	Dr n.		
	Health Health tem 27 other tr		20a. Method of Disposition ( ) 20b. Place of Disposition ( Name of )	Date 20c	. Location - City or Tox	MI) 21234 wn, State
altimore,	Pages nent of ant: ff it ury or o	1	1 Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  Cemetery, crematory or other diage)  EVANS FUNE PALCHARL 4-20	2-04	FOREST 1	4(1) mD
Balti	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	TIMORE.	mD 212	34.
	70 F # 9	_	23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac of	MPEL 800 or respiratory arrest	NHARFOR	Approximate
	Physician		23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Respiratory Failure			Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Du to (or as a consequence 1):			
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		F	
	cuted nd ransit	Examiner	cause. Enter Underlying Cause Classic Classic Classic Classic Canada Can	of laptice	lcon'	
8760,	cate be executed physician and the burial-transit		resulting in death) Last Due to ( as a consequence of):			
687	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	edicai	d			
Вох	ires that the death certific signed by the attending p d be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deliver	1
о. В	the att	ysicia	in the past 12 months?  1   Yes   2   No   9   Unknown   9		Month	Day Year
<u>α</u>	s that the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the	e cause of death?
ords	w requires been sign should be	led b		1 🗆 Yes	2 No 3 Proba	bly 4 □Unknown
Vital Records,	e law r has be ge 2 sh	Completed		24a. Was an autopsy performed	prior to com	sy findings available pletion of cause of
<u>a</u>		e Co	25. Was case referred to medical 26. Place of Death	1 ☐ Yes 2		2□ No
	Physicle this cert al direct	ToB	examiner?   Hospital: Other	10	6 □Other (Specify,	
o uc	iing Pl	ion	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how in	njury occurred	
Division of	Attence r death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		and Number or Rural	Route Number,
ó	Itel or rs afte el Dira	Cert	4 ☐ Homicide determined building, etc. '(Specify)	City or Town, St	are)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	edicai	29a. Certified (Check only one) Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause ed at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)
	To the within ?	Mec	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, D	Pay, Year)
)			D24671	4	121/04	•
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #N(N) TITE  11 N Calcut St. Bahimae ND 2(7)	7. 12		
•	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature			
	Registr	ar	APR 2 3 2004 Server & Sparker			10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 49 A 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HARFORD De ed. CTR peake 7. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 221-26-083 Director Usual Residence of Decede 10a, State 10c. City, Town or Location 10h County 10d. Inside City Limits or 28a-f show other treumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 21034 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 2 should be filed within 72 hours and Mental Hygiene.
Is marked other than "neturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 ORDIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr any injury or other treum <u>20059.</u> 150 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highland Pres. Ch. Comperu 21. Signature of Funeral Service License 22. Name and Address of Facility PALTIMOR 21234 E, MD EVANS FUNERAL COAPEL, 8800 HARFORD RD 23a. Part1. Enter the dise se, or complications that caused the shock, or heart failvire. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): attending physicien Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) o. ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, λq 1 🗀 Yes 2) No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? rmed? 200 No 2 No 1 Yes 1 Tes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 🗌 Yes 2 **2** No Medical Certification: To 1 > npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death, (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 3 2004

Corbin, Andrew

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 12603 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ammil 19 Pay 2004 Year **Physician** 1751 P. M Corey Scott Chesla /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3824 Federal Hill Road -Jarretusvilla If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Months | Days | Hours | Min. | Sept. | 17, 1971 -Jarrettsville Harford 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1⊠M 2□F Mary land Yrs. Director 212-70-1872 32 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28e-f show Forest Hill Harford 1 ☐ Yes Z ☐ No Md. Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21050 2037 Pointview Circle Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Maryland 21215-0036 ō white 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry heat and air than Elementary/Secondary (0-12) College (1-4or 5+) conditioning sheet metal mechanic 12 years ith and Mental Hygie 27 is marked other t traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Linda Woods Chesla Lawrence Chesla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3824 Federal Hill Road, Jarrettsville, Md. 21084 Lawrence Chesla/father other t Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) = 5 permit. Page Department of important: If any injury or once. Bayview Crematory i4/26/04 Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 25a. Part1. Enter the disease, or pomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician a.compressional asolyxia and disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4 Pregnant at time of death 5 Other (specify) ed by the a o. 9 Unknown ۵ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No icate has been sig r. page 2 should b 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 1∆Yes 2□ No performed' Vital Yes 2 🗆 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Certification; To 1 XYes 2 □ No 4 ☐ Nursing Home 5 ☐ Residence 6 x Other (Specify) (Scene) his 28a. Date of Injury (Month, Day Ye 27. Manner of Death 28b. Time of 28c. Injury at Work? 8d. Describe how injury occurred After Division 5:47PM 1 Natural 5 Pending -19-04 1 ☐ Yes 2 No 2 Accident
3 Suicide investigation after death 2 f. Location (Str. et and Number of R., al Rouse) 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. 4 Homicide ō 9 arao within 24 hours a
To the Funeral D
completely filled i 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, Teath occurred at the time, date and place, and due to the cause(s) and mainten as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the

State Registrar 29b. Signature and title of certified

Q

OLLAK 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

April 20, 2004

BY	DIXON		State of Maryland / D		rtment of H				giene	12001
			Registrar  1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
	Physici /Medio		BOBBY LEE DIXON					APRIL	20°, 2004°	10:10 AM
	Examir		4a. Facility Name (If not institution, give street and number) 700 NORTH WOODINGTON ROAD		4b. City, Town, or BALTIM				4c. County of Death	1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bin	rthday)	If Under 1 Year Months Days	If Under	24 Hrs. 8	Date of Birth	9. Birth	nplace (State or Foreign
	Director		214-30-3332 5/	Yrs.	Months Days	110013			7, 1947	MD
	and and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	n or Loc	ation					10d. Inside City Limits
	the Marylar 28e-f show	ō	MD N/A DATETA	(ODE						1 ∑Yes 2 □ No
	28e	rec	MD N/A BALTIM	10KE	10f. Zip Code			1	log. Citizen of What Co	untry?
	23a or	Funeral Director	700 N. WOODINGTON ROAD		2122	29			USA	43
	death	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His Yes, specify Cubar	spanic Orio	gin? (Speci	fy Yes or No-	14. Race - Amer	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23e or 28e-1 show event. The M-dical Examination to the modified at	by	1 Never Married 2 Married 1 Yes, Give Year or Dates:		□ Yes 2∏ No	Specify:	i, Puello Ai	carr, etc.)	Specify:	ACK
20	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupa		t of working		16b. Kind of Business/I	
2	ithin ithin	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. Di	O NOT use retired)	)	or working			
121	filed with Hygiene. other than			<i>I</i> AREI	HOUSEMAN					R WAREHOUSE
and	should be filed within of Mental Hygiene. marked other than matic event, I've M	o Be	17. Father's Name (First, Middle, Last)  JAMES DIXON					First, Middle, I H LANGI	Maiden Sumame)	
Ξ	s 1 and 2 should t if Health and Ment item 27 is marked other treumatic	2		. Mailing	Address (Street a				LE1 , City or Town, State, Z	ip Code)
	1 and 2 Health a iem 27 is		The second secon	_	N. WOODIN					1229
altimore,	es 1 and of Health fitem 27 r other tr			f Disposi	ition (Name of atory or other place	a)	Dat	-	20c. Location - City or 1	own, State
Ē	0 0		EXBURIAL 2 Cremation 3 Hemoval from State	-	MEMORIAL		4-27-	-2004	BALTIMORE	MD
alt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee				y JAME	ES A. M	ORTON & SON	NS F.H., INC
8	20529		James 4. Morton	17	01 <b>-</b> 31 LA	URENS	S ST.	BALTI	MORE, MARYI	
			23a. Pagh. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	not enter	1 .				est,	Approximate Interval Between
	Priysician	ri i	Immediate Cause (Final disease or condition resulting in death)	c (	Ali vo	uh	1/4	renze		Onset and Death
	/Medical Examiner		Due to (or as a consequence of	of):						
		j.	Sequentially list conditions, b. Due to jor as a consequence of	ofl:						
	ned Insit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć.	execu in and ial-tra	Examine	resulting in death) Last Due to (or as a consequence of	of):						
8760,	cate be executed ohysician and the burial-transit		d							
9	rtifica ng ph as th	Medi	IE ECAMIC.							
Вох	eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 <b>□</b> E	Ectopic pregnancy				23d. Date of deliv	,
O.	ne dea the at hed fo	Physician/Medical	in the past 12 months?  1		Other (specify)				Month	Day Year
<u>α</u>	that the de ed by the a detached		Part II. Other significant conditions contributing to death but not resulting in	n the unc	tertving cause give	n in Part I		23e Did toh	pacco use contribute to	he cause of death?
Records,	sign d be	ed by	Chame alcoholism						es 2 No 3 Pro	
ecc	law requ as been 2 shoul	Completed						24a. Was ar		opsy findings available empletion of cause of
= R		Con						perforn	ned? death? 2 ☐ No 1 <b>D</b> res	2 No
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?				of Death /	Check only on	θ)	
of	Phys this aldii	٦.	1 XYes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Out 27. Manner of Death 28a. Date of Injury 28b. T		3□ DOA Othe	4 LI NUI	-		ence 6 Other (Speci	fy) AT SCENE
LO O	ding After fune	tion	1 dNatural 5 Pending (Month, Day Year) Ir	Time of njury	28c. Injury Work' M 1 □ Y	at ? ′es 2.∐.N		J. Describe no	w injury occurred	
Division	l or Attending after death. Director; After in by the fune	fica	3 Suicide 6 Could not be 28e, Place of Injury - At home, far	ırm, stree		00 201		. Location (St	reet and Number or Run	al Route Number.
<u>S</u>	after after Dire	Certification;	4 Homicide determined building, etc. (Specify)	,				City or Town		
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	death o	occurred at the time estigation, in my opi	e, date and inion, deat	d place, and h occurred	d due to the ca at the time, da	ause(s) and manner as s ate and place, and due t	stated. o the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier		29c. License	number		29	9d. Date signed (Month,	Day, Year)
6	0 42 4		VIR 111K		0.C	.M.E				2004
1	12		30. Name and address of person who completed cause of death Item 23a) (	(Type, P	rint)	-1K0-006				
_	,		7.		,	Bal+	imore	. Marv	land 21201	
	s Sta		31. Date filod (Month, Day, Year) 32. Registrar's Signature	1	als			,y	CILCUI.	
1	Registr	ar	APR 2 3 2004 Server 10	apo	RNI					

	1 - For State Registrar	State of I	maryland /		tificate of			giene Reg. No	0001	1260
	1. Decedent's Name (First, Middle,	Last)					2. Date of Dea Month			3. Time of Death
an al	Myrtle Josephi	ne Donalds	on				April	20	2004	8:45 P
er	4a. Fecility Name (If not institution,	give street and numb	er)		4b. City, Town, o	r Location of Dea	th	4c.	County of Deat	h
	Laurel Regional 5. Social Security Number		Age (In yrs. last	hirth day)	Laurel If Under 1 Year	If Under 24 Hr	s. 8. Date of Birt		ince Geo	
	039-16-8538	1  M 2 X F	78	Yrs.	Months Days	Hours Min		y, Year)	25 Phoc	hplace (State or Fore buntry) de Island
	Usual Residence of Decedent		70				Aug. 1,	17	ZJ KIIOC	de Island
	10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Lim
Director	MD Prince	George's	Laure	el						1 ☐ Yes 2 □
Dire	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Co	untry?
rai	7508 South Arbo	<u> </u>		10.1		0707			USA	
Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Decede Armed Force d 1 ☐ Yes 2	eş?	13. V	vas Decedent of H f Yes, specify Cuba	ispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		14. Race - Ame Black, White	
by F	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Date		1	I□Yes XXNo	Specify:			Specify: Wh	nite
	15. Decedent's		16	Sa. Deced	lent's Usual Occup	ation		16b. Ki	ind of Business/	Industry
Completed	(Specify only highest Elementary/Secondary (0-12)	Grade completed)  College (1-4)	or 5+)	life. L	kind of work done of OO NOT use retired	during most of wo	orking			
PO	12th	Ø		Bart	ender			Res	staurant	=
Be (	17. Father's Name (First, Middle, La	ast)				18. Mother's Na	ıme (First, Middle,	Maiden	Sumame)	
၉	Unknov	<b>v</b> n				Unk	nown			
1	19a. Informant's Name/Relationshi	p (Type, Print)	1	9b. Mailin	g Address (Street	and Number or F	lural Route Numbe	r, City o	r Town, State, 2	Tip Code)
_ 5	Donna Faina/Dau	ghter				bory Lar	ne, Laure			
	20a. Method of Disposition 1   Burial 2 □ Cremation 3	B □Removal from Sta	come	i of Dispos Itery, cren	sition (Name of natory or other place		Date	20c. Lo	ocation - City or	Iown, State
	* 4 □ Donation 5 □ Other (Spe		Fort		coln Cem.				ntwood,	
	21. Signature of Funeral Service Li	100 V	7	0.000			onaldson			
	Janus		M01103				, Laurel		20707	
	23a. Part1. En er the disease, or co shock, or east failure. List of	nly one cau e on eac	h line.	o not ente	er the mode of dyin	ig, such as cardia	ic or respiratory an	rest,	- 1	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	а.			Acciden	t				1 Day
Н			as a consequence							Several
e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		erioscie		ic Cardio	vasculai	Disease		2	years
m L	cause. Enter Underlying Cause (Disease or injury that initiated events									
Examin	resulting in death) Last	Due to (or	as a consequenc	ce of):						
cai		d								
led								-		
hysician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregnancy n 2 DFetal dea	ath 3⊡	Ectopic pregnancy	,			23d. Date of deli	
sici	in the past 12 months? 1 □ Yes 2 □ No		t at time of death		Other (specify)				Month	Day Year
Phy	9 Unknown									
þ	Part II. Other significant condition	s contributing to deat	n but not resulting	g in the ur	iderlying cause giv	en in Part I.				the cause of death?
-Bed							I LALI Y	es 21		obably 4 Unkno
ted t					-				24b. Were au	topsy findings availa
eted							24a. Was a autop	sy	prior to d	completion of cause
ompieted							autop: perfor	sy	prior to death?	completion of cause of 2010 No
eted	25. Was case referred to medical examiner?	Hospital					autop: perfor	sy med? 2 🖾 No	prior to death?	completion of cause
To Be Completed	examiner? 1  Yes 2 No	Hospital: 1 🔯 Inp		Outpatien		er: 4 🗆 Nursing	autop perfor 1 Yes eath (Check only or Home 5 Resid	sy med? 2 A No ne) ence	prior to death? 1  Yes	ompletion of cause ∂
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edical Certification; To Be Completed	examiner?  1 Yes 2 XNo  27. Manner of Death 1 XNatural 5 Pending investiga 3 Suicide 6 Could no determin  29a. Certifier (Check only one)  1 Yes 2 XNo  2 Pending investiga determin	28a. Date of I (Month, tion at be ed 28e. Place of building.	Injury 28t Day Year)  Injury - At home, etc. (Specify)  ast of my knowleds of examination	o. Time of Injury farm, stre	28c. Injun Work M 1 = set, factory, office	er: 4 Nursing y at k? Yes 2 No ne, date and place	autop perfor 1 Yes  ath (Check only or 1884 Describe h  281. Location (S City or Tow e, and due to the curred at the time, c	sy med? 2 (A No ne) ence (ow injurative t anim, State, state, and date and	prior to codeath? 1 Yes 6 Other (Specty occurred  d Number or Ru ) and manner as i place, and due	in No No No No No No No No No No No No No
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edical Certification; To Be Completed	examiner?  1 Yes 2 XNo  27. Manner of Death  1 XNatural  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of I (Month, tion at be 28e. Place of building.  Physician: To the be caminer: On the basiand manner	Injury 28th Day Year) Injury - At home, etc. (Specify) ast of my knowleds of examination stated.	o. Time of Injury  farm, streeting, death and/or inv	28c. Injum Work M 1 Deet, factory, office a occurred at the time restigation, in my office 29c. Licens D 2 4 7	er: 4 Nursing y at k? Yes 2 No ne, date and place pinion, death occurs a number	autopoper autopoper in a perfor 1   Yes    ath (Check only or    Home 5   Resid    28d. Describe h  28f. Location (S    City or Tow    e, and due to the curred at the time, c	symed? 2 (2 No ne) ence (ow injur itreet ann, State) cause(s) date and	prior to codeath? 1 Yes 6 Other (Specty occurred  d Number or Ru ) and manner as i place, and due	in No No No No No No No No No No No No No
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001

12606

							Cei	rtificate	e of l	Death			Reg. No.	/	1 2 0 0 0	
			Decedent's Name (First, Middle, Last)						2		2. Dete of De Month	eth Dey	Year	3. Time of Death		
	.Physicia		Patricia	a Ann Fra	ances Do	owd						april	21	2004	1:20 pm	
	/Medic Examin		4e Fecility Neme (If not institution, give street and number)				4	b. City, To	Town, or Location of Death 4c. County of Deeth							
		3	Mercy H	Hospice					F	Balti	more					
	Funeral		5. Social Security N	lumber 6.	Sex	7. Age (In yrs.		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birl (Month, Da	h v. Year)	9. Birthp	place (State or Foreign	
	Director	L	214-19-33	343	1□ M 2√xF	22	Yrs.					MAR. 9		Tex	•	
	D >	-	Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location									- 1	10d. Inside City Limits			
	aryle sho	<u>~</u>	Toa. Stete	,			•							1.	1 □ Yes 2 □ No	
	28a-1	ect	MD 10e. Street end Nur	Anne Ar	rundel	S∈	evern	10f. Zip	Codo				10g. Citizen of	What Cour		
	<b>a</b>	ă		ontreal F	bee.				1144	1			USA	WHEE COU	my r	
	eath	Funeral Director		Jillear r		edent Ever in U	S 13 1				igin? (Spe	ecify Yes or No		ce - Americ	can Indian.	
_	ter d	١٩	11. Maritel Status	ied 2 Merried	Armed F		10.1	f Yes, speci	ify Cuba	n, Mexica	n, Puerto	Rican, etc.)		ck, White,		
21215-0020	irs af	ρ	3 ☐ Widowed		If Yes, G	IVE		1□Yes 2	<sup>™</sup> Nο	Specify	:		Speci	'n∶ wh	ite	
ŏ	2 hou	Be Completed by		15. Decedent's E			16a. Dece	dent's Usua	Occup	etion			16b. Kind of E	Business/Inc	dustry	
215	7 uin 7	pe	(Specify only highest grede completed)  Elementery/Secondary (0-12) College (1-4or 5+)			·	(Give kind of work done during most of working life, DO NOT use retired)									
7	a the state of the	E	12	many (0-12)	College	(1 401 01)	Nai	l Aes	thet	cicia	n		Beaut	y Sal	on	
	office Hyge	Se C	17. Father's Name	(First, Middle, Las	1)					18. Moth	er's Name	(First, Middle,	Maiden Suma	me)		
<u>Jai</u>	Aente Aente d'Aente d'	2	Marvin 1	Lee Naymi	lck					Hya	ng Si	im Yi				
Maryland	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene. I the marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street	and Numb	er or Rure	el Route Numbe	er, City or Town	n, State, Zip	Code)	
	and 2 alth 27 i		Marvin D	Naymick -	- father						, Sev	vern, M				
altimore,	of He		20a. Method of Disg		□Domovel from	20b. F	Place of Dispo cemetery, crer	sition (Nam natory or ot	e of her plac	(e)	1	Date	20c. Location	- City or To	own, State	
ΗĔ	Pages nent of int: If its ary or o			□ Cremation 3 D 5 □ Other (Speci			dowrid	ge Mer	m. F	ark	4	/24/04	Elkri	dae, I	MD	
alt	permit. Pages Department of Important: If it any injury or c		21. Signature of	neral Service Lice	nsee	<del>-</del>	22	. Name and	d Addres	ss of Facili	tv					
m	89 2 2 8			1	) 1	M0129						., Elkr			dge MP, Inc. .075	
	H = 2.4		23a. Pert1. Enter the	he disease, or con	plications that	caused the deat								1	Approximate Interval Between	
	Physician /Medical		3110011, 017102	art randro. Elot om	0110 02000 011									+	Onset and Death	
			Immediate Cause (	(Final			5/101	000	(	7	in	testin	21	:		
	Examiner		resulting in death)		а		or as a consec									
	₽ #	<u>ne</u>		_	h											
	ecute and trans	Eam	Sequentially list co	nditions,	0	Due to (or as a consequence of):							1			
Ö,	entificate be axecuted ding physician end se es the buriel-transit	Ē	cause. Enter Underlying Course (Disease or injury that initiated events  Due to (or as e consequence of):													
68760,	ate to	edicai Examiner	that initiated events Due to (or as e consequence of): resulting in death) Last													
×	entific fing p	Me		L	d									į		
Bo	aath certif attending for use es															
	that the dailed by the a	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Per						en in Pert	I.	23b. Did tobacco use contribute to the cause of death?					
P.0	that the sed by datac	됩										1 ☐ Yes 2 ☐ No 3 ☐ Probably			bably 4 Unknown	
ds,	S 50 8	Completed by										/as an autopsy 24b		. Were autopsy findings		
ŏ	v raquira been si	ete											rmed?	ave	eilable prior to inpletion of cause	
36	has law	ם											_		death?	
<u></u>		8										101		11	☐Yes 2☐ No	
Ĭ.	ilcian: Thi cartificate rector, pag	Be	25. Was case refer examiner?	_	Hospital:				Oth	or.		(Check only o	_			
o	- ± 0	5 T	1 ☐ Yes 2 ☐ 27. Menner of Deat		28a. Date	of Injury	ER/Outpatier 28b. Time of		Bc. Injun Worl			me 5 Residence 128d. Describe 1			hospice	
Division of Vital Records,	h. After funer	ţ	1 Natural	5 Pending investigetion	(Moi	nth, Day Year)	Injury	м		k? Yes 2.⊡	No	and a second control of the second se				
isi	deet deet ctor: y the	fica	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, street, factor						office	office 28f. Location (Street and Number or Rural Route Number			I Route Number,			
<u>≥</u>	effer Dire	ert	4 ☐ Homicide	determinet	build	ling, etc. (Specif	y)	100				City or Tov	m, State)			
	polta ours seral	Medical Certification:	29a. Certifier	1 Certifying Pl	hysician: To the	e best of my kno	wledge, death	occurred a	at the tim	ne, date ar	nd place, e	end due to the	cause(s) and m	anner as st	tated.	
	Hoo 24 h Fur letaly	8	(Check only one)	2 ☐ Medical Exa		pasis of examine nner stated.	tion end/or in	vestigation,	in my o	pinion, dea	ath occurre	ed at the time,	date and place,	and due to	the cause(s)	
_	To the Hospital or Attandin within 24 hours effer deeth. To the Funeral Director: Africompletaly filled in by the fu	Me	29b. Signeture and	I title of optitier	Λ -			29c.	Licens	e number			29d. Date sign	ed (Month,	Dey, Year)	
	1			DW	100	( -		1	N	DRS	4		41:	21/20	MUS	
	r	)	30. Neme end eddr	ress of person who	completed car	se of deeth (Iten	n 23e) (Type,	Print)	J. 1						<u> </u>	
			Davi		seberg		301 5	TOP	AUL	PL	Bo	eltimo	re m	d. i	20215	
	Sta	te	31. Dete filed (Mon			Registrar's Signa	ature	Spons	les							
	Registr	ar	APF	3 2 3 200	4		/	/	٠							

		•	For State Registrar	State of Marylan		tment of H			jiene	L 12607		
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last)	VIS		b. City, Town, or	Location of Deel	2. Date of Dea A Month D3 1	100	14 2:00A M		
	Funeral Director	ier	Renaissance Garder 5. Social Security Number 6. Sex	ns @ Riderwoo	d Villla	ŕ	ilver St If Under 24 Hrs Hours Min.	oring	Montgome 9. B			
	e Maryland la-f show	ctor	Usuel Residence of Decedent  10a. State 10b. County  Maryland Anne Arus		y, Town or Loca	tion				10d. Inside City Limits 1 ☐ Yes 2 No		
	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatin and Mental Hygiene. nit: If teen 27 is marked other than "naturel" or items 23a or 28a-f show in: If teen 27 is marked other than "naturel" or items 20 is notified any or other traumatic event, I as Medical Exam har must be notified any.	Funeral Director	10e. Street and Number  441 Cleveland Roa  11. Marital Status	12. Was Decedent Ever in U	.S.   13. Wa	10f. Zip Code 21090 as Decedent of Hi	spanic Origin? (S	Specify Yes or No-	United Sta	•		
9600		þ	1 Never Married 2 Married 3 Widowed 4 Divorced		II 10	es, specify Cuba Yes 2 (No	Specify:	to Rican, etc.)	Black, What Specify:	White		
Maryland 21215-0036		Completed	(Specify only highest grade Elementary/Secondary (0-12) 12 years 4	College (1-4or 5+) Years	(Give kii life. DC	ied Publ	furing most of wo	untant	Internal	Revenue Ser.		
aryland		17. Father's Name (First, Middle, Last)  18. Mother's Name (First,  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route							acy			
			Shirley E. Davis (V	emoval from State	Place of Disposit cemetery, crema	ion (Name of tory or other place	θ)		ID 21090 20c. Location - City of Brooklyn Pa			
Baltimore,	permit. Pag Department Importent: I any injury o			Wayne Osterli	ng 22. Mc 23	7 E. Pat	s of Facility Lyniak I	Funeral H ve. Balti	lome, P.A. more, MD	21225		
	Physician /Medical		23a. P (11. Enter the disease, or complishoth, et head failure. List only or Immediate Cause (Final disease or condition resulting in dealh)	e cause on each line.	card	the mode of dying	g, such as cardia	OV	est,	Approximate Interval Between Onset and Death		
O. Box 68760,	Examiner	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	mono	ery e	mboli	sni		Iday		
	death certifii e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3 □E	ctopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year		
ords, P.	The law requires that the de tie has been signed by the a bage 2 should be detached t	by	Part II. Other significant conditions cor Hyper Her	10	obacco use contribute to the cause of death?  /es 2 \( \text{No} \) 3 \( \text{DProbably} \) 4 \( \text{Unknown} \)							
of Vital Records,	To the Hospital or Attending Physicien: The law re which 24 hours after dealy attentions after dealy from the Completely filled in by the funeral director, page 2 shown of the page 2 shown at the page 2 shown at the page 2 shown at the page 2 shown at the page 2 shown at the page 2 shown at the page 2 shown at the page 2 shown at the page 2 shown at the page 2 shown at the page 2 shown at the page 3 sho	e Completed	TYAN SIL	ent Ischenuc attack					24a. Was an autopsy performed?  1 Yes 2 1 Yes			
Ž		To Be	examiner?	lospital: 1   Inpatient 2	ER/Outpatient	3 DOA Othe	ath (Check only or Home 5 Reside	ne 5 Residence 6 Other (Specify)				
0 4			27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at c?		ow injury occurred			
Division		Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - AI h building, etc. (Specin	M 1 Tyes 2 No of Injury - Al home, farm, street, factory, office 281. Location (Street and Nu				treet and Number or I n, State)	Rural Route Number,		
		edical	(Check only 2 Medical Exemit one)	sician: To the best of my kno ner: On the basis of examina and manner stated.		stigation, in my op	oinion, death occ	urred at the time, d	late and place, and du	ue to the cause(s)		
	S # 5 PO	×	29b. Signature and title of certifier	who many	MD	D59	524	2	April 21			
1222	1.2		30. Name and address of person who co	ANA, 3110 (	GRACE	FIELD !	ROAD,	SILVER S	SPRING,	MD 20904		
May.	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature P							

DHMH 17 Rev 1/2001

ORIGINAL

			1- State of Marylai Registrar	•	artment of He rtificate of D		ental Hygien Reg. N		12608			
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Lillian Darnell			2. Date of Death Month Di April 9	ay Yeer 2004	3. Time of Death 10:30Å				
	Examin		4a. Fecility Name (If not institution, give street and number)  Catonsville Commons		sville	4.	4c. County of Death Baltimore					
	Funeral Director		212-10-4912 1□M 2K F 99	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Dey, Year Nov. 20,19	9. Birth Cou 904 Mai	nplece (Stete or Foreign intry) ryland			
	hours after death with the Maryland tural; or itema 23a or 28e-f ahow al Exercitive final be notified at	Director	Usual Residence of Decedent  10a. State 10b. County 10c. C  Maryland Baltimore  10e. Street and Number	ity, Town or Lo Cato	nsville		100 C	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2☐No			
	na 23a or	Funeral Dir	502 Academy Road  11 Marital Status 12. Was Decedent Ever in 1		21228 Was Decedent of Hisp	panic Origin? (Spe	cify Yes or No-	U.S.A.	ican Indian,			
21215-0036	ours after or iter	by	Armed Forces?  1 ☑ Never Married 2 ☐ Married  1 ☐ Yes 2 ☑ No  1 ☐ Yes, Give  Year or Dates:		f Yes, specify Cuban,	Mexican, Puerto F Specify:	Rican, etc.)	Black, White				
	in 72 n • na	To Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Unknown  College (1-4or 5+)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired) MStress	ion ring most of workir	ng	Kind of Business/Ir	ndustry			
Maryland 2	should be filed with ind Mental Hygiene s marked other than umatic avant, the		17. Father's Name (First, Middle, Last) Unknown	bear		8. Mother's Name	(First, Middle, Maide					
	1 and 2 shou Health and N Iam 27 is mai other traumal		19a. Informant's Name/Relationship (Type, Print)  Rachel Murray Letourneau (POA)	Merca	ng Address <i>(Street an</i> antile Ban	k Bldg.	Baltimore,		1827			
altimore,			1 🖾 Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  WC	cemetery, cren odlawn	sition (Name of matory or other place) Cemetery	4-17	-2004 Woo	Location - City or Todlawn, M	laryland			
Ball	permit. Page Department of Important: If any injury or			16		son Avenu	e Catonsv	sville, i ille, Ma	ryland 21228			
E	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death Support Condition as a support Condition resulting in death)									
	Examiner	Examiner	Sequentially list conditions, it any leading to meeting cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
8760,	cate be executed physicien and the burial-transit	edical Certification; To Be Completed by Physiclan/Medical Exal										
	ne death certiff the attending hed for use as		IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 S/No 9 □ Unknowrf  23c. If yes, outcome of pregrant 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	very Day Year			
0	w requires that the bean signed by should be detact		Pan II. Other significent conditions contributing to death but not re	sulting in the u	nderlying cause given	in Part I.		tobacco use contribute to line cause of death?  Yes 2 No 3 Probably 4 Unknown				
II Reco			Basal cell convinoma	b.		24a. Was an autopsy performed?  1 ☐ Yes 2 【 No 1 ☐ Yes 2 ☐ No			ompletion of cause of			
Division of Vital Records,	Attanding Physician: The redeath.  ector: After this certificate by the funeral director, pag		25. Was case referred to medical examiner?  1									
	9 4 4 5		1 Matural 5 Pending (Month, Day Yeer) Injury Work? 2 Accident investigation 3 Suicide 4 Homicide determined (Month, Day Yeer) Injury Work?  M 1 Yes 2 No  28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Run City or Town, State)									
_	To the Hospitel or Attant within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed Manifold 1997, Year)  31. Date filed Manifold 1997, Year)  32 Certifier  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed Manifold 1997, Year)  32 Certifier  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)  31. Date filed Manifold 1997, Year)  32 Certifier  1 A Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)  31. Date filed Manifold 1997, Year)  32 Certifier  33 Certifier  34 Certifier  35 Certifier  36 Certifier  36 Certifier  37 Certifier  38 Certifier  39 Certifier  30 Certifier  30 Certifier  30 Certifier  30 Certifier  30 Certifier  30 Certifier  30 Certifier  3									
)		W	29b. Signature and title of certific Paper (UI)		29c. License	7541	29d. D.	ate signed (Month,	Day, Year) 2004			
	<b>B</b>			em 23a) (Type,	Holling:	Ferry o	Rd Ba	ltinou,	MD21227			
	Sta Regist		31. Date filed Month Day, Year) A	P.	poels							

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:15am Raymond H. Flagg April 20 2004 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ivy Hall Nursing Center Middle River Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 MM 2 ☐ F 213-14-0559 83 Feb. 4, 1921 Director Massachusettes Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar natal by notified at 1 ☐ Yes 2€ No Baltimore Middle River Directo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6631 Ebnezer Road 21220 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify:White þ 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Transmission Mechanic permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: if item 27 is marked other ths eny injury or other traumatic event, the gince. 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hazel Demanie 0 Harry Flagg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Solgat / friend 6631 Ebnezer Road Baltimore MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Holy RosaryCemetery 4/23/04 Baltimore MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 on 23a. Part1. Enter the disease, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a cons vivence of Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Man or of Death 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1 O ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp on FOHN 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar APR 2 3 2004

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of	Maryland		artment rtificate			ınd Menta		iene 19. No 200 [	12610
	Physici /Medio		1. Decedent's Name (First, Middle, L. Dorothy	ast)			Fish	IER			te of Deatl	Day Yea	
	Examin		4a. Facility Name (If not institution, gi	ve street and num	ber)		4b. City, To	wn, or Lo	cation of			4c. County of De	
			Johns Hopkins	HOSPITAL	-		BALTI					N/A	
	Funeral Director			Sex 1□M 2□F X	7. Age (In yrs. Ia 65	ast birthday) Yrs.	Months [		f Under 2 Hours	Min. (M	te of Birth onth, Day, 11,	9. 8 1938 Ma	irthplace (State or Foreign Country)
	and *		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation						10d. Inside City Limits
	Maryli feho	tor	Md. N/A		100.0.0,		timore	2					1 X Yes 2 □ No
	h the	Director	10e. Street and Number				10f. Zip C	ode			10	g. Citizen of What (	Country?
	23a c		5521 Cedonia Ave	nue				212	206			United St	ates
980	i within 72 hours after death with the Maryland Jiene. r then "naturel", or items 23a or 28e-f ehow the Medical Exercit errorational	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Deced Armed For 1 Tes If Yes, Give Year or Da	2 🔯 No		Was Deceder f Yes, specify 1 ☐ Yes 25		anic Orig Mexican, Specify:	in? (Specify Yo Puerto Rican,	es or No- etc.)	14. Race - An Black, Wh Specify: W	
5-0	72 ho	eted	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Dece	ient's Usual (	Occupatio	on ina most	of working	1	6b. Kind of Busines	s/Industry
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of work OO NOT use	retired)	goo.	o. woming	į		
d 2	Hyge th		12 years 17. Father's Name (First, Middle, Las	t)		secre	tary	18	3. Mother	's Name (First	Middle. N	educatio	n
/lan	o d ita	To Be	Joseph Teong	,						la Lai			
Maryland 21215-0036	s 1 and 2 should f Health and Men ftem 27 is marke other treumatic		19a. Informant's Name/Relationship Donna Torres/da									City or Town, State, Md. 210	,
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [		tate ce	ace of Dispo metery, crer	sition (Name natory or othe	of er place)		Date	2	Oc. Location - City of	
altim	1. E E E		* 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	fy)	Gar		. Name and	Address o	of Facility			Baltimore	
ä	permi Depar Impo any ir		Buan a. L	iller			610 W	Ma.	cPha	il Road	d. Be	f Bel Air <del>l Air, Md</del>	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on ea	ch line.						ratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. INIK	A PAREN	OCHY!	YAL H	EMM	iorr	HAGE			WEEKS
	Examiner		Se wentially list conditions	DIABE	TES N	NELLY	rus						YEARS
8760,	icate be executed physician and sthe burial-transit	al Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hypen	r as a conseque r as a conseque	N							YEARS
.O. Box 6	the death certificate y the attending phy. ched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		th 2 Fetal on the strime of dea	death 3	Ectopic pregi Other (speci					23d. Date of do	elivery Day Year
rds, P	sign d be	by	Part II. Other significant conditions	contributing to dea	ath but not result	lting in the ur	nderlying caus	se given ii	n Part I.	23			to the cause of death?  Probably 4 Unknown
Vital Records,	The law ate has b page 2 s	Completed									a. Was an autopsy perform Yes 2	prior to	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				04		of Death Chec			
of		: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of	Injury 2	R/Outpatien 28b. Time of						ce 6 Other (Spenial of the control o	ecify)
ion	Attending I r death. sctor: After by the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month	, Day Year)	Injury	М	Injury at Work? 1 Tyes	2 □ N	0		,,	
Division	or At fter c pirec	Certification;	3 Suicide 6 Could not l 4 Homicide determined	288. Place C	of Injury - At hom g, etc. (Specify)		eet, factory, o	ffice			ation (Strey or Town,	et and Number or F State)	lural Route Number,
_	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the b miner: On the bas and manne	sis of examination	rledge, death on and/or inv	occurred at t estigation, in	he time, o	date and on, death	place, and due n occurred at th	to the cau e time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the To the Comp	Ž	29b. Signature and title a certifier	AP	A			icense nu				d. Date signed (Mon	_
)	4			· hue	, MD			: S -	0	00	Ap	ril, 20,	2004
	/	(	30. Name and address of person who CARLOS ALVES 60	completed cause				TIMO	RE	MARYL	(KVA	21287	
	Sta Registr		31. Date filed (Month, Day, Year)		gistrar's Signatu	IL6	back		1.0	- Pry	***		
			75 NAS S 3 2004	A Carper		of pla	yours	-					

027	11		1 - For Amend & Un	pend Item#	,9 <u>5-</u> M,a	nyland in Pen Ce	91tr9/PIX rtificat	8/04H e of L	ealth a	and M		giene Reg. No. 4		12611
			1. Decedent's Name (First, Mic	ddle, Last)							2. Date of De	ath		3. Time of Death
	Physici /Medio		Teresa Shir	clen Fre	ed						Apri]	19,	2004	2057 P M
1	Examir		4a. Facility Name (If not institu				4b. City,	Town, or	Location	of Death		4c. C	County of Death	
			Howard Count	y General	Hosp	ital	Co	lumb	ia			H	oward	
	. Funeral Director		5. Social Security Number 220-08-3261	6. Sex 1 ☐ M 2 🛣	7. Age	(In yrs. last birthday, Yrs.	If Under Months		if Under Hours	Min.	8. Date of Birl (Month, Da May 28	h y, Year)	9. Birth Cou 9 7 2 MD	place (State or Foreign ntry)
1	and w		Usual Residence of Decedent 10a. State 10b. Cour	ntv		10c. City, Town or L	ocation						Т-	10d. Inside City Limits
	r 28a-f show	ctor	MD Howa	· _		LAUREL								1 ☐ Yes 2 🌠 No
	death with the Maryland ms 23a or 28a-f show trust be rollified at	al Dire	10e. Street and Number 8730 Birkenh	nead Cou	rt		10f. Zip	Code 207	723			10g. Citiz	en of What Cou US	•
5-0036	is 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene, itam 27 ia marked othar than "natural", or Items 23a or other traumatic avent, the Medical Examiner must be	by Funeral Director	11. Marital Status  1 Never Married X N 3 Widowed 4 Divorce	Armed 1 ☐ Ye If Yes.	ecedent Ev Forces? es 2 <b>X</b> No Give r Dates:	1	Was Decedif Yes, spec		ispanic Ori n, Mexicar Specify:		cify Yes or No Rican, etc.)	-	4. Race - Ameri Black, White, Specify: Wh	
21215-0	within 72 ho ene. than "natur ne Medical	Completed	15. Decec (Specify only hig Elementary/Secondary (0-12	,	e (1-4or 5+	(Give	dent's Usua kind of wo DO NOT us	rk done a se retired,	ation during mos )	t of workin			d of Business/In	
121	iled w tygier har ti		17. Father's Name (First, Midd	5+		tea	cher		10 Mathe	ela Nama	(First, Middle,		ic sch	ools
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than " fraumatic avant, the Moo	To Be	James Garfie		len,	Jr.		I			binsor		umame)	
	and 2 sho lealth and m 27 ia ma her trauma		19a. Informant's Name/Relation		husba								Town, State, Zip L , Md .	
altimore,	Pages 1 are tent of Hearn of Hearn of Hearn of Itam		20a. Method of Disposition 1 □ Burial 2 □ Crematic		om State	20b. Place of Dispo cemetery, cre Crestla	matoni or o	thar nlaci	e)		/04 (		ation - City or To	
Baltin	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Servi		^	Clestia	2. Name G	arde	L Ta L DS cilit	yWit	zke Fi			es,Inc.
	205 g		23a. Part1. Enter the disease,	njeur	at anyoned the	5	555	Twir	n Kno	olls	Rd, C	Colu	mbia,	Md. 21045 Approximate
	Pnysician /Medical	r II	shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	ist only one cause o	n each line tral v	alve prolap					respiratory ar	rest,		Interval Between Onset and Death
	Examiner		Convention liet conditions	Due	to (or as a	consequence of):								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due	to (or as a	consequence of):								•
8760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due	to (or as a	consequence of);								
9	certificate Iding phys Ise as the	Medi	IF FEMALE:											
O. Box	death e atter id for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Section 12 No 9 Unknown		e birth 2 egnant at ti	Fetal death 3	Ectopic pr Other (sp					23	d. Date of delive Month	Day Year
σ.	requires that the de een signed by the a rould be detached t	by Phy	Part II. Other significant cond	iitions contributing to	death but	not resulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco use		ne cause of death?
Records,		eted						-		_	1 N	- 1-		ably 4 Unknown
al Re	The lar ate has page 2	Completed									24a. Was autop perfor	sy	prior to con death?	psy findings available mpletion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medi examiner?	Hospital:				Otho		of Death	(Check only o	ne)		
ō	Phys this al dir	P.	1 X Yes 2 No	1	☐ Inpatient			PRODUCTION OF	4 LI NU				Other (Specifi	y)
	Jing After fune	tlon	27. Manner of Death  1 XNatural 5 Pen 2 Accident inve		te of Injury Ionth, Day	Year) 28b. Time o	M 2	8c. Injury Work	at ? ′es 2 ∐ !		8d. Describe h	ow injury (	occurred	
Division	or Attanding after death. Diractor: After in by the fune	Certification:	3 Suicide 6 □ Cou	ld not be 28e. Pla	ace of Injungilding, etc.	y - At home, farm, sti (Specify)				-	8f. Location (S City or Tow	treet and i	Vu <i>mber or Rur</i> a	l Route Number,
1	To tha Hospital or Attant within 24 hours after death To tha Funaral Diractor: completely filled in by the	edical Ce	(Check only 2 Medic	ying Physician: To	basis of e	xamination and/or in	n occurred vestigation,	at the time	e, date an	d place, ar	nd due to the o	ause(s) ar late and p	nd manner as st ace, and due to	ated. the cause(s)
	thin 2 tha	Med	one) 29b. Signature and title of certi	and m	anner state	d.		. License					signed (Month,	
	T win		70010	1 Um	, 1 =	2- 1/10	250							
			30. Name and address of pers	on who completed as	auso of do-	thytam 22al Tuna	Print)	oa	.,TC			Apr	11 20, 2	2004
			Annual Control	reenberg	M.D			enn :	Stree	t, Ba	altimor	e, Ma	aryland	21201
4	Sta		31. Date filed (Month, Day, Ye	107		s Signature	1 to							
	Registr	ar	APR 2 3	ZUU4 /	der.	St. 15084								

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Certifica	ate of	Death		Reg. No. 2	104	12612
	Dhysisian		me (First, Middle, La	ist)					2. Dete of D Month	eath Day	Year	3. Time of Death
-	Physiciar /Medica	.61 8 11	HUR		- 6	OVASTE	5_		APRIL		2004	1505
	Examine	An Cantha Maria		re street end number)				4b. City, Town, o		th 4c. County	y of Death	
		1922	Searles	Rd				Baltim		Bal	timor	e
	Funeral	5. Social Security			je (In yrs. lest b	Month	der 1 Year ns Days			irth lay, Year)	9. Birthpled Country	ce (Stete or Foreign
	Director	218-01-9	681 L86	11 x M 2□ F 8	9	Yrs.			Aug. 2	4, 1915	Massac	chussetts
	pur *	Usual Residence	of Decedent 10b. County		10c. City. To	wn or Location						I. Inside City Limits
	taryta sho										1.00	1 □ Yes 2√□ No
	the N	Maryland 10e. Street end N	Baltimo	ore	Bal	timore	Zip Code			10g. Citizen of	Mhat Counta	
	ter death with the Marylan ttems 23s or 28s-f show ther must be notified at	1022 50		3			1222			United	-	
	feath 75	11. Marital Status	arles Road	12. Was Decedent	Ever in U.S.			Hispenic Origin? (	Specify Yes or N		ce - American	
020	Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If them 27 is marked other than "natural", or items 23a or 28a-f show may injury or other treumatic event, the Medical Expriner must be notified at any injury or other treumatic event, the Medical Expriner must be notified at an Inc.  To Re Commission by European Disorbor	1 ☐ Never Ma	rried 2 Married 4 □ Divorced	Armed Forces?  1  Yes 2 X  If Yes, Give  Year or Dates:			pecify Cub 2 No	Hispenic Origin? ( pen, Mexican, Pue Specify:	irto Rican, etc.)		ick, White, etc <sup>fy:</sup> White	
ō	2 hor	(0-	15. Decedent's E	ducation	16	e. Decedent's U	sual Occu	pation	a deia a	16b. Kind of B	usiness/Indu	stry
21215-0020	2 should be filed within 7 and Mental Hygiene. is marked other than "reumatic event, the Med To Re Commiss	Elementary/Sec	ecify only highest gra condary (0-12)	College (1-4or		life. DO NOT lanager	work dane Tuse retire	during most of wo	orking	Food Se	ervice	
b	be file d othe event,		e (First, Middle, Lest	)				18. Mother's Na	ame (First, Middle	e, Maiden Surnar		
<u>la</u>	Menta Menta	Consta	ntine Gova	astes				Mary Ka	aramedos			
Maryland	and beand beand beand beand	19a. Informant's I	Name/Relationship (					t and Number or F		-		ode)
≥.	1 and 1 Health em 27 i	Cleopat	ra Govaste	es/Wite		922 Sea		Road I	Baltimor	e, MD 21	.222	
ore	of Herical	20a. Method of Di	•	Removal from State	20b. Place cemet	of Disposition ( <i>f</i> ery, crematory o	Vame of or other pla	ice)	Date	20c. Location	- City or Town	, State
Ē	Pag ment: I		5 ☐ Other (Specif		Oak I	awn Cem	etery	J	4/23/04	Baltin	nore, N	Maryland
Baltimore,	permit. Pages 1 and Department of Health important: If Item 27 eny injury or other t pnce.	21. Signeture of	uneral Service Licer	PMAR.	WW/22	Bradle	y-Asl	ess of Facility nton-Matt				
	_	23a Part Finter	the disease or com	plications thet caused one sause on each li	the death. Do	not enter the m	111OV node of dyi	V Spring	Road B	alt., MC arrest.		pproximate
1	* Physician	shock, or he	aft failure. List only	one sause on each li	ne.			-			i In	iterval Between Inset and Death
A. A.	/Medical	Immediate Cause		7	ind cho	of Ton	intia	1			į	
	Examiner	disease or condit resulting in death	)	a	Due to (or as a	consequence	MUIN of):	Accident			1	
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	artificate be axecuted ing physician and e as the buriel-transit	Sequentially list of	conditions.	b		consequence of		range				
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	the at the at the def	Part II. Other sign	ificant conditions	ontributing to death b	ut not resulting	in the underlying	g cause gi	ven in Part I.	23b. Did	tobacco use co	ntribute to th	ne cause of death?
P.0	± bo €	Hyper	tension						1 🗆	Yes 2□ No	3 Probab	oly 4 Unknown
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Records,	v require								24a. Was	an autopsy ormed?	availa	autopsy findings
O O	as be										of dea	letion of cause ath?
<u>~</u>	The la ate has page 2								10	Yas 2XNo	1 □ Y	′es 2□ No
of Vital	certifica ractor, p		erred to medical					26. Place of De	eath (Check only	one)		
<u></u>	S S D	1 ☐ Yes 2 💆	₫ No	Hospital: 1   Inpatie		·	DOA		Home 5⊠Res	idence 6 □Oth	er (Specify)	
	Per Per Per Per Per Per Per Per Per Per	27. Manner of Dea	ath 5 ☐ Pending	28e. Date of Inju (Month, Da	ry 28b. <i>y Year)</i>	Time of Injury	28c. Inju Wo		28d. Describe	how injury occur	red	
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Division	tal or Attending P is after death.  al Director: After ted in by the funeration:	3 ☐ Suicide 4 ☐ Homicide	dotorminad	28e. Place of Inj building, et	ury - At home, f c. <i>(Sp</i> ec <i>ify)</i>	arm, street, fact	ory, office			(Street and Numb wn, State)	er or Rural R	oute Number,
Ω	ittal ours at Dilled i								1, 14			
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A complately filled in by tha tu-	29a. Certifier (Check only one)	1)K   Certifying Ph 2 ☐ Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination e	e, death occurre nd/or investigati	ed at the ti on, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time,	date and place,	anner as state and due to th	id. e cause(s)
	within 2 To the compla	29b. Signature en	d title of certifier		1100.	2	29c. Licens	se number		29d. Date signe	d (Month, Da	v. Year)
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	J	20 Name	toon of	oomeloted as a six	anth /ltan 00	(Tune Dri-1)		- 1 - 4-		7	120	1
	0			completed cause of d			DVIIC	BAYVIEW	CIDCIE	DNTIMA	F MD	2/224
	State	MICHAEL  31. Date filed (Mo	HARPER, P nth, Day, Year)	32. Registr	NG, <u>I/O</u> ar's Signature	3505 HO	17 N/N -2	LATTUILN	CINCLE,	DAIL! IFIUM	-11-10	
	Registrar		PR 2 3 200		nar	6 1	in w	1				

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10:40 PM **Physician** 2004 Greathouse James Harold Poril /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Franklin Square
5. Social Security Number 6. S Posedale Baltimore Hospital Center 8. Date of Birth (Month, Day, Year) July 30, 1946 Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Months 113 M 2 □ F 214-44-3026 57 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner runst by notified at 1 Yes 2 No Director Maryland | Baltimroe Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 905 Barron Avenue 21221 "natural", or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 1 Never Married 2 Married 1 ☐ Yes 2 🖾 🗙 o If Yes, Give Specify: Specify ð ear or Dates White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education other 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked o Willard Greathouse Reta Beverage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Virginia Avenue, Baltimore, Maryland 21221 June McClelland (Daughter) other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State ö Apr. 24, 2004 Baltimroe, Maryland Gardens Of Faith injury \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21 Signatura et la Persi San ce Licensee any in Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1 Immediate Cause (Final disease or condition resulting in death) Infarction **Physician** Myocarolial /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed use as the burial-tran Due to (or as a consequence of): attending physician Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco.use contribute to the cause of death? 2 sign be ( 3 Probably 4 Unknown 1 Yes Completed page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No certificate 1 Yes Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only or Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes No Certification: To this 28a. D. te of Injury (Month, Day Year) funeral 27. Manner of leath 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Division Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptified 29c. License number MID D0060453 Solver D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Anastasios Saliaris 9000 Franklin Square Drive Baltimore, MD 21237 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 34.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Bernice Mary Gross April 21, 2004 10:38 a<sup>™</sup> /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** 1 Brett Court, Apartment 113 Baltimore Essex ESSex

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Feb. 8, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 204 215 10 8543 83 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County rthen "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 TYes 2 TXNo Maryland Baltimore Essex Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1 Brett Court, Apartment 113 21221 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 IX Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H Is marked of Walter Ordakowski Rose Starcynski 2 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 Old Philadelphia Rd. #10 Aberdeen, Md. 21001 William S. Gross (Personal Rep.) Health a or other tra Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of His
Important: If Iten
eny injury or oth 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 4/24/2004 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility.

Bruzdzinski Funeral Home, P.A.

Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Lice 1407 Old Eastern Avenue, Essex, Maryland 21221 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and burial-tran Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day jo in the past 12 months? 1 ☐ Yes 2 🔀 No 4☐Pregnant at time of death 5 Cther (specify) the detached o 9 Unknown 9 Unknown þ σ. signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2X No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2X No 3 DOA 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A death. 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🏋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Day, Year) 31. Date filed (Month. State Registrar

**ORIGINAL** 

		-	For State Registrar	State of Maryland / [	Department of Health and M Certificate of Death	lental Hygier	- 2006	12615
	Physici		1. Decedent's Name (First, Middle, L Blanche E	· Garthe		2. Date of Death Month	Day Year 17,2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gi Saint Joseph	ve street and number) Medical Center	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 209-09-3835  Usual Residence of Decedent	Sex 1 M 2 F 7. Age (In yrs. last bir	rthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth 917 Bra	place (State or Foreign intg) (COLOCK, PA.
	death with the Maryland ms 23a or 28a-f show rmust be nutlified at	ctor	Maryland Balt	imore Co. Tow	n or Location USON			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	uth with the 23a or 28 ust be no	Funeral Director	1607 Jeffe	rs Rd.	101. Zip Code 21204	10g.	Citizen of What Cou	intry?
	or Ita	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?, 1	13. Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	ican Indian, , etc.
21215-0036	n 72 ho • natur	Completed	15. Decedent's 8 (Specify only highest g		Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  HIML MAKE	ing 16b	Kind of Business/Ir	Home
Maryland 2	s 1 and 2 should be filed withi f Health and Mental Hygiene. item 27 Is markad othar than othar traumatic evant, the M	To Be C	17. Father's Name (First, Middle, Las	Hart	18. Mother's Nam Sadie	e (First, Middle, Maid	ien Sumame) Keally	
	and 2 sho alth and 1 27 is ma		19a. Informant's Name/Relationship Mrs. Diane W	(Type, Print) Heatley (Daught	o. Mailing Address (Street and Number or Rur 100 7 Saxon Hill	Dr. Coci	ty or Town, State, Zi	o Code), 21030
Baltimore,	0 0		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spec	Removal from State	of Disposition (Name of the Commission of the Co	22, 2604 20c.	Baltimo	4
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Liv	· Jan, M-	2325 York R	atives Fo	neralta nium,	MD ZIOG3
	Physician	0 0	Immediate Cause (Final disease or condition	mplications that caused the death. Do by ope cause on each line.  METABOLIC AC	not enter the mode of dying, such as cardiac IDOSIS	or respiratory arrest,	í	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		on: INAL BLEEDING		i i	2-3 DAYS
٥,	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence				
68760	ificate be ex g physician as the burial	edical		d				10.79
Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	a 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv Month	rery Day Year
ds, P.O.	uires that the d signed by the d be detached	by	Part II. Other significant conditions	contributing to death but not resulting i	in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to to 2 No 3 Pro	2.00
Division of Vital Records,		Completed				24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
Vita	ysician: This certificate director, pag	o Be (	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 <b>X</b> ER/O	Other	h (Check only one)	6 Other /Soesi	(6/)
on of	ding Ph J. After th funeral	H	27. Manner of Death  1 Natural  2 Accident  5 Pending investigati	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury at Work?  M 1   Yes 2   No	28d. Describe how in		97
Divisi	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not determine	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	281. Location (Street City or Town, St		al Route Number,
	To the Hospital or At within 24 hours efter or To the Funeral Direct completely filled in by	edical C			e, death occurred at the time, date and place, nd/or investigation, in my opinion, death occur			
<b>.</b>	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number D 39215	29d.	Date signed (Month,	Day, Year)
	13			o completed cause of death (Item 23a)	(Type, Print)	1//	7 0	,
	Sta Regist		GAIL CUNNINGHE  31. Date filed (Month, Day, Year)  APR 2 3 2004	32. Registrar's Signatur	SLER DRIVE, TOWSON	V, MARYLI	AND 8120	14

August   A	TIMORE Birthplace (State or Foreign Country) ARYLAND  10d. Inside City Limits 1 Yes 2 2 100
A. Facility Name (If not institution, give street and number)   4b. City, Town, or Location of Death   4c. County of the street and number   30 27   VILLOUGH BY ROAD   PARKVILLE   5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Year)   12 M 2 F   66 Yrs.   4c. County of the street and number   4c. County of the street and number   4c. County of the street and number   4d. City, Town, or Location of Death   4d. County of the street and number   4d. County of the street	Death  Death  TIMORE  Birthplace (State or Foreign Country)  ARYLAND  10d. Inside City Limits  1 Yes 2 Xio
Funeral Director  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Ac. County of G. Sex  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.  Usual Residence of Decedent  4c. County of G. Sex  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.  Usual Residence of Decedent	Birthplace (State or Foreign Country)  ARYLAND  10d. Inside City Limits  1 Yes 2 X to  It Country?
Funeral Director  5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.  Usual Residence of Decedent  5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.  Usual Residence of Decedent	10d. Inside City Limits 1 Yes 2 100 It Country?
Director  Usual Residence of Decedent  Director	10d. Inside City Limits 1 Yes 2 100 It Country?
	1   Yes 2   Yes 2   Yes   American Indian,
To be a state   10b. County   10c. City, Town or Location   10d. Zip Code   10	1   Yes 2   Yes 2   Yes   American Indian,
The street and Number  109. Street and Number  109. Street and Number  109. Citizen of What I log. Citizen of What	It Country?
10. 2 Code  10. 2	American Indian,
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give Wind of Married 3 No Indicated 1	
Specify:   Specify:	Vhite, etc.
Specify: V Specify: V	A /
15. Decedent's Education (Specify only highest grade completed)  [Specify only highest grade completed]  [Specify only highest grade completed]  [Give kind of work done during most of working life. DO NOT use retired)  [Specify only highest grade completed]  [Specify only highest grade completed]  [Specify only highest grade completed]  [Specify only highest grade completed]  [Specify only highest grade completed]  [Specify only highest grade completed]  [Specify only highest grade completed]  [Specify only highest grade completed]	VHITE
College (1-4or 5+)	ass/Industry
NECHANICAL INSPECTOR VIACHIN	VIST
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	0131
Public of the policy of the po	)
The state of the s	le, Zip Code)
DHARON JORON / AUSTER SOS MANEHUR THE MONETON 200. Date 200. Location - City	MD JIII
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City	or Town, State
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20a. Method of Disposition 1 Service Service Licensee 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City 20c. Location -	ENARYLAND
21. Signature of Funeral Service Licensee 22. Name and Address   Facility EVANS CHAPEL OF A SERVILLE,	MEMORIES
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only procause on each line.	Approximate
Physician Immediate Cause (Final disease or condition	Interval Between Onset and Death
/Medical resulting in death)  Due to (or as a consequence of):	Jeans
Examiner  Sequentially list conditions, b	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):	
that initiated events c.  Due to (or as a consequence of):	
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Co. Due to (or as a consequence of):  d. Due to (or as a consequence of):	
683 as the graph of the control of t	
FFEMALE:   23d. Date of months   23d. Date	
in the past 12 months?    Solution   Solutio	Day Year
1   Yes 2   No 9   Unknown   9   Unknown   9   Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute	n to the equal of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  12 Yes 2 No 3  24a. Was an autopsy performed autopsy performed death 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N	Probably 4 Dunknown
24a. Was an 24b. Were	
24a. Was an autopsy performed performed to the performance of the perf	autopsy findings available to completion of cause of 1?
	∕es 2□No
25. Was case referred to medical examiner?  1	pecify)
28a. Date of Injury 28b. Time of Injury Work?	
S 1 Suicide 6 Could not be	
27. Manner of Death  1	Rural Route Number,
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner	as stated
25. Was case referred to medical examiner?  1	lue to the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Mc	onth, Day, Year)
1 Howard Flines 138403 4-21	-4
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
NR. Howard Steiner 5/001 Loch Raven Blvd, Baltimore M	D 21239
Registrar APD 2 3 2004	
DHMH 17 Rev 1/2001	

ORIGINAL

		1. Decedent's Name (First, Mid	ddle, Lasi	t)							2. Date of De	aath		3. Time of Death
Physici		, , , , , , , , , , , , , , , , , , , ,		Oriet	а	Ho1ness	3				Month 4	15	2004	15:00 M
/Medi Examir		4a. Facility Name (If not institu	tion, give	street and num	ber)		4b. City,	Town, or	Location of	of Death		4c. Co	unty of Death	10100
		Gilchrist	Cent					/son				Ba1		
Funeral Director		5. Social Security Number 138-46-6241	6. Se	X ⊒M 2527 F	. Age <i>(In yn</i> 83	s. last birthday Yrs.	Months		If Under Hours	Min.	8. Date of Bill	rth a <i>y, Year)</i> -1920	9. Birthp	place (State or Foreign http://
_		Usual Residence of Decedent									0-31	-1920	west	Indies
nylane ihow		10a. State 10b. Cour			10c. (	City, Town or L	ocation						1	Od. Inside City Limits
8a-f	cto	Md	N/A			Balto_								X☐Yes 2☐No
with the		10e. Street and Number 2500 W. Belve	dere	Avenue			10f. Zip	2121	5				of What Cour	ntry?
ns 23	eral	11. Marital Status	dere		ent Ever in	U.S. 13.				gin? (Spe	acify Yes or No	U S	Race - Americ	can Indian.
nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: if tiem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or each other traumatic.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ M		12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	M No		If Yes, spec		Specify:	i, Puerto	acify Yes or No Rican, etc.)		Black, White,	
72 ho natur dical	eted	15. Deced (Specify only hig	ent's Edu	ucation de completed)		16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa	ation during mos	t of worki	ina		of Business/In	
within ne. ihan	mpl	Elementary/Secondary (0-12		College (1-	for 5+) N / Δ		DO NOT us					King	Highwa	y Hospital
filed with Hygiene. Ither than	ပ္ပိ	12th grade 17. Father's Name (First, Midd	le, Last)		M/A	Nul	565	AIU		or's Name	(First, Middle	Maiden Sur	mame)	
id be ental ked o	To Be	Joseph Fost									Stewar		,,,,,,,	
2 should be tand Mental be is marked of aumatic ever		19a. Informant's Name/Relation	nship (T	ype, Print)		19b. Mail	ng Address	(Street a	and Numbe	er or Rura	al Route Numb	er, City or To	wn, State, Zip	Code)
1 and 2 Health a em 27 is		Stanford Hol	ness	- Step		5330	Cuth	bert	Aven	ue	Balto,	Md 21	215	
Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 Burial 2 ☐ Crematic	n 3□F	Removal from Si	200	Place of Disponentery, cre	matory or o	ne of ther plac	θ)		Date		on - City or To	
permit. Pag Department Important: I any in[ury o	1	`4 ☐ Donation 5 ☐ Other	(Specify)	4		Cypress					2004		lyn, N	.Y.
permit. Departr Importa		21. Signatore of uneral Servi	CO LIP			2					ch F/H			
	$\vdash$	23e Part 1. Inter the disease.	or comb	lications that car	ised the de	ath Do not en	43	00	Wabas	h Av	enue ]	Balto,	MD 213	2.1.5 Approximate
		23a. Part 1. Enter the disease, shock, or heart failure. L Immediate Cause (Final	ist only			-								Interval Between Onset and Death
Physician / /Medical		disease or condition resulting in death)	-		as a conse		10cm	0~	I & Mai	24	Primas	24		Months
Examiner					as a conse	squerice or,								
P. F	Je.	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		b. — Due to (o	r as a conse	quence of								
acute and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c										
ite be executed lysician and ne burial-transit	cal Ex	resulting in death) cast		Due to (o	r as a conse	iquence of):								
# × 9				d										
The law requires that the death certificat ate has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	2	23c. If yes, outco								23d.	Date of delive	ırv
death e atte	ICla	in the past 12 months?		4⊡Pregna	th 2∏Fe nt at time of		]Ectopic pro ] Other (sp.					i	Month	Day Year
that the de led by the a detached t	hys	9 Unknown	- 1	9□ Unknov		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
res tha	þ	Part II. Other significant cond	itions co	ntributing to dea	th but not re	sulting in the u	nderlying ca	ause give	en in Part I.					ne cause of death?
w require been si should I	ted										10	Yes 2 ₩ No	o 3 Prob	ably 4 Unknown
e law has b	Completed										24a. Was autop		prior to cor	psy findings available apletion of cause of
		25.14									1 Yes	2 X No	death? 1 ☐ Yes	2□ No
	o Be	25. Was case referred to medi examiner?  1 Yes 2 No	100	Hospital:	patient 2[	☐ ER/Outpatie		Othe	-		Check onl			handing
g Phys er this eral di	$\vdash \vdash \downarrow$	27. Manner of Death		28a. Date of	Injury	28b. Time o		8c. Injury	at	1	ne 5 🗆 Resid			nospice
ath. r: After ne funer	atlo	E LI / NOOIGOIN	stigation	(INOTITI)	Day Year)	Injury	М	Work	r ∕es 2 🔲 l	No				
r Atte ter de irecto	Certification;	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ld not be imined	28e. Place o	f Injury - At	home, farm, st	reet, factory	, office		2	28f. Location (S City or Tox	Street and Nu vn. State)	ımber or Rura	l Route Number,
ital o irs aft ral Di iled ir														
Hosp 4 hou Fune Fely fill	Medical	(Check only 2 Medic	ying Phy al Exami	sician: To the b	is of examir	nowledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, a h occurre	and due to the ed at the time,	cause(s) and date and plac	manner as st	ated. the cause(s)
To the Hospital or Attending i within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Med	one) 29b. Signature an Mittle of certification		and manne	r stated.			. License		-			aned (Month, L	
F 3 F 8		Milk		LIV	$\sim$		1	70		77				
	1	30. Name and address of pers	on who co	ompleted cause	of death (Ite	m 23a) (Type.	Print)	/ /	0 /	-		Trac		
P			ovile		660	N.	Cha	Nes	0	011	rmore	mo	21200	1
Sta	ite	31. Date filed (Month, Day, Ye.			gistrar's Sigr							-		
Registr		APR 2 3												

			1 - For amend Item #5,p Registrar	State of Marylan er FH, 0830, 4/28	d / Depa /2006	artment of H	lealth and M Death	lental Hygie	ene 2004	12618
	Dhysisi		1. Decedent's Name (First, Middle, Las					Date of Death     Month	Dav Year	3. Time of Death
	Physici /Medio		Everett F. Hildel	orand				April 2	1, 2004	10:00 p M
2	Examin	er	4a. Facility Name (If not institution, give			1	Location of Death		4c. County of Death	1
			956 Hillswood Ros 5. Social Security Number 6. S		last hirthday)	Bel Ai	If Under 24 Hrs.	8. Date of Birth	Harford	place (State or Coming
	Funeral Director		213-07-5276 217-40-8953	61 M 2□F 87	Yrs.	Months Days	Hours Min.	Jan. 29,	1917 Mar	place (State or Foreign intry) yland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	ō			•					1 ☐ Yes 2 ☐ No
	288	Director	Md. Harford  10e. Street and Number	1	De	1 Air 10f. Zip Code		10g	. Citizen of What Cou	
	3a o		956 Hillswood Roa	ad. Apt. I		2101	4	U	nited Stat	es
36	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Depirtment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event. The Medical Examinant until to Indiffed all ange.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ▼Yes 2 □ No If Yes, Give Year or Dates:	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐xNo	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
Ş	2 hou	ed	15. Decedent's Ed	ducation	16a. Deced	dent's Usual Occup	ation	16	6b. Kind of Business/li	ndustry
712	nin 7	Completed by	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done of OO NOT use retired	during most of workii  )	ng		
21	d with	E O	10 years		dye	pressman	1	e	nvelope co	ompany
land	ild be file lental Hy kad oth ic event	To Be (	17. Father's Name (First, Middle, Last) Joseph M. Hildeb				18. Mother's Name Mary (u		<sup>iden Sumame)</sup> Hildebrand	l
Maryland 21215-0036	nd 2 shou alth and M 27 Is mai		19a. Informant's Name/Relationship ( Wayne Hildebrand			-			City or Town, State, Zi.	
Baltimore,	Pages 1 a ent of Hea nt: If item ry or othe		20a. Method of Disposition  1	Removal from State	emetery, cren	sition (Name of natory or other place Cemetery			c.Location - City or T	
Balti	permit. Dep rtm Importa any nju		21. Signature of Funeral Service Licer	Viller	22				f Bel Air, 1 Air, Md.	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat	h. Do not ent					Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Pneum Due to (or as a consequence Chronic	onsa uence of):	com	munity alminary !	acquire	ed End Stage	Onset and Death 2 WKS
, 0,	tificate be executed by physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):		J		J	
68760,	rtificate br ng physic s as the bu	Medicai	IF FEMALE:	d						
.O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
<u>α</u>	quires that in signed b uld be deta	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribute to t	
Vital Records,	ysician: The law requira is certificate has been sii director, page 2 should b	Completed						24a. Was an autopsy performer	prior to co	opsy findings available impletion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Unanitali	TE:	Oth	26. Place of Death	(Check only one)		
of	Physi r this c ral dire	유	1 □ Yes 2 No		ER/Outpatien		4   Nursing Hon		e 6 ☐Other (Speci	(y)
u C	ding f	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	vat k? Yes 2 □ No	28d. Describe how	injury occurred	
Division	or Attence frer death Diractor: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, str		-	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical Ce	29a. Certifier  (Check only one)  (Check only one)	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or inv	n occurred at the tim restigation, în my op	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
	o the ithin o the	Me	29b. Signature and title of certifier	and marrier states.		29c. License	number	29d.	. Date signed (Month,	Day, Year)
	⊢ ≯ ⊢ ŏ		> TAMAL A	Elevisia i	ND	D-	48175	c.	1/2 2/ALL	
	3		30. Name and address of person who	- C	23a) (Type,	Print)	-10103	0 21-	7 01	
			-0.  01	32. Registrar's Signa	ture	HULLIAM	io. ~ i M	10 21	201	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 3 2004	Sendra	4					

HUNSINGER, Myron CARI Rallimore. Marvland 21215-0036

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P.O. E
Records,
of Vital
Division o

			Please 1	ype or Prin					•		egible.	
			For State	State of Ma	aryland /		tment of F <i>ificate of I</i>			,	2001	
		•	Registrar  1. Decedent's Name (First, Middle, Last)			0071	moute or i	Dealit	2, Date of Dea	Reg. No.	4004	3. fime of Chat
	Physicia		Myron E. Hun	singer					Month O4-	Day BO	Year	9: 45-ci M
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)	-		4b. City, Town, o	Location of Death	,	77.5	unty of Death	,,,,,
			Franklin Square 1	tospital	Cente	r	Roseda	Je		Bo	2 Himos	Te
	Funeral		5. Social Security Number 6. Sec	7. Age M 2□F	e (In yrs. last		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	, Yeer)	9. Birthp	lace (State or Foreign
	Director		188-05-2394	(	93	115.			Aug. 6,	1910	Penn	sýlvania
Puels	Moi ii		10a. State 10b. County		10c. City, T	own or Loca	ation		<u></u>		1	0d. Inside City Limits
, Was	18 Tell	ctor	Maryland Baltimore	2		1	Baltimor	e				1 ☐ Yes 2 ☐ No
di di	or 28	Director	10e. Street and Number				10f. Zip Code	4.0.0.1		-	of What Cour	itry?
de de	8 23a nust t	rail	4112 Kahlston 1					1236			.s.A.	
ab ac	Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent ! Armed Forces? 1 ☐ Yes 2 ☑ N		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (S <sub>i</sub> an, Mexican, Puert	pecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
	Jo ', or	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	••	1 (	□Yes 2X No	Specify:		Sp	pecify: Whi	te
III Z I Z I 3-0030 he filed within 72 hours after death with the Mandard	neture lical E	ted	15. Decedent's Edu (Specify only highest grad	cation	1	6a. Decede	nt's Usual Occup	ation	king	16b. Kind	of Business/Inc	dustry
7	. ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			during most of wor.	, , , ,	σ.		
7	Hygiene. other than ent, tre M		12th Grade  17. Father's Name (First, Middle, Last)			Truci	k Driver	18. Mother's Nam	o (First Middle		cking	
	Mental H arked of atic ever	Be	Grover Hunsing	10 h				Minnie	ти. Ти		mame)	
ar yid	and Mental Hygiene.  marked other than "neturel", or Items 23a or 28e-1 show imail: event, the Medical Exertiner must be notified at	ဥ	19a. Informant's Name/Relationship (Ty			19b. Mailing	Address (Street	and Number or Ru			own, State, Zip	Code)
;, We	perim: Tages is an a substantial Department of Health and Men Importent: If item 27 is marken any injury or other treumatic once.		Mrs. Anita Hunsi	iger (wi	1			n Road, 1		-		
. ע	of Hei		20a. Method of Disposition		20b. Place	e of Disposit	tion (Name of story or other place		Date		ion - City or To	wn, State
antimor	ant: If		1 🕅 Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)		St. M	lichae	l Luth.	Ch. 4/23	/04	Balti	more, 1	Maryland
Dall	Depart Import any inj	1	21. Signature of Funeral Service Licens	90 ^				ss of Facility Sc				
<b>.</b>	105 5 3		1 / Cag	land	2			ir Road,			D 21236	
			23a. Pany. Enter the disease, or combined, or heart failure. List only of Immediate Cause (Final	ne cause on each lir	ne deam. L	o not enter	the mode of dyin	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
	nysician /Medical		disease or condition resulting in death)	Due to (or as			menia_					
	xaminer			Atrial	10	Ha tie	200					
		ner	Sequentially list conditions, in any leading to miniocials cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as			(3)					
de	Ind	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Cereb	ro Va	50 Lla	r Diseas					
ou,	cian a		resulting in Geattly Last	Due to (or as			books					
	physi s the t	Physician/Medical		nenp	relay	) 19	11.622				1	
אַס אַס	nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome						23d	. Date of delive	ry
	e atte	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			ctopic pregnancy Other (s <i>pecify)</i>				Month	Day Year
5 5	by th	hys	9 Unknown	9□ Unknown							<u> </u>	
The law requires that the death conditions	igned be de	by	Part II. Other significant conditions con	ntributing to death be	ut not resultin	ig in the und	lerlying cause give	en in Part I.				e cause of death?
cords,	s uee Pould	ted	Prostate Cancer							es 2 N	lo 3 Prob	ably 4 Unknown
	has b	Completed		-					24a. Was a autop: perfor	sy	4b. Were autoprior to condeath?	osy findings available apletion of cause of
VICE T	ficate or. pag		25. Was case referred to medical						1 ☐ Yes	2 🗓 No	1 ☐ Yes	2□ No
N Selection	s certi	To Be	examiner?	lospital:	nt 2∏ER/	/Outpatient	3□ DOA Oth	26. Place of Dea	ome 5□Resid		Other /Specifi	1
5	Ber thi		27. Manner of Death	28a. Date of Injur (Month, Day	ry 28	b. Time of Injury	28c. Injun Worl		28d. Describe h			,
	or: Af	atic	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2 □No				
DIVISION	in by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home c. <i>(Specify)</i>	, farm, stree	t, factory, office		28f. Location (S City or Town	treet and N n, State)	umber or Rura	I Route Number,
J 19	ours a		29a. Certifier Certifying Physics	sicien: To the best of	of my knowled	dge, death o	occurred at the tin	ne, date and place.	and due to the c	ause(s) and	d manner as st	ated
DIVISION OF VICE	This is no specially a factoring tripercent. The fact requires that he death controlled to be secured. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	(Check only 2 Medicel Exami	ner: On the basis of and manner sta	examination	and/or inve	stigation, in my o	pinion, death occur	red at the time, o	late and pla	ice, and due to	the cause(s)
F OF	To the comp	Σ	29b. Signature and title of certifier				29c. Licenso	e number	2 54 )	9d. Date si	igned (Month,	Dey, Year)
	$\sigma_{i}$		10ky11/10/2	<b></b>			1AF23	284123	204	4/2	0100	+
	\		30. Name and address of person who co	1 Cxnn	-		- 1	Jaim R	11:	. И.	1712	37
	Sta	te	Dr. Andel Meger 31. Date filed (Month, Day, Year) APR 2 3 2001,		ar's Signature	ilin 5	quale 1	JIIVE W	וסומונניט	e) 110	110	
	Registr		APR 2 3 2004	Serve	w /	9	box					
				2								

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ES 10:00 8.M /Medical 4a. Fecility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 000 Baltimo If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1□M 20F 80 Yrs. Director 8.3 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location or flems 23a or 28e-f ehow 10d Inside City Limits traumetic event, the Madical Examiner must be notified at Baltimor Macyland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6092 209 Completed by Funeral é 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 22 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Experiment of Health and Mental Hygiene. Inportent: If item 27 is marked other any injury or other transpore. Black, White, etc. 1 Never Married 2 Married 20 No 1 🗆 Yes 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ome Ma 10 N 17. Father's Name (First, Middle, Last) To Be 18 Mother's Name (First Middle Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No Son 2115 20b. Place of Disposition (Name of cametary\_crematory or other place) 20a. Method of Disposition 20c. Location -1 ☐ Burial 2 Cremation 3 Removal from State Evans Funeral Chapel Belta 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1 Enjer the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** MyoCaro disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. I have underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknown ģ been signed be should be deta Part II. Other significant conditions contributing to death put not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alzheimers 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has the autopsy performed? Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Hospital: 1 🗆 Yes 2 2 No Cther: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33750 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 2 3 2004

DHMH 17 Rev 1/2001

**ORIGINAL** 

			1 - For State Registrar	State of Maryland	/ Depa	urtment of Health an tificate of Death	d Mental Hy	•	1262
000	Physic /Medi Examii	cal	4a. Fecility Name (If not institution, g	TWASK(W) ive street and number)		/	2. Date of De Month APRICA	ath Day Yeer	3. Time of Death  4 03 5 4 N
	Funeral Director		5. Social Security Number 6. 152-24-3480 Usual Residence of Decedent	Sex 1 <b>X</b> M 2 F 7. Age (In yrs. last	st birthday) Yrs.	If Under 1 Year If Under 24  Months Days Hours I	Jin. (Month, Da	ly, Year) Co	hplace (State or Foreign buntry) Craine
	Ba-f show	ctor	10a. State 10b. County HOWard		Town or Lo	cation			10d. Inside City Limits 1 ☐ Yes 2√2 No
	h with it	al Dire	10e. Street and Number 6342 Beachwood	Drive		10f. Zip Code 21046		10g. Citizen of What Co	ountry?
326	within 72 hours after death with the Maryland one. then "natural", or Items 23s or 28s-f show he Madical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☆ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Tives 2 No 195 If Yes, Give Year or Dates: 195	0   '	Vas Decedent of Hispanic Origin Yes, specify Cuban, Mexican, P  Yes 2 X No Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Rece - Ame Black, White	nican Indian, e, etc. 7hite
1215-00	within 72 hou ene. then "natura he Med cal E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	16a. Deced (Give life. L	ent's Usual Occupation kind of work done during most of DO NOT use retired)		16b. Kind of Business/	Industry
nd 2	ld be filed ental Hygi ked other Ic event, t	ae Be	17. Father's Name <i>(First, Middle, La</i> Petro Iwaskiw	5+ ]	Elecr		er Name (First, Middle, Samycia		v't.
ē,	s 1 and 2 sh if Health and item 27 is m other traum	2 9	19a. Informant's Name/Relationship Stephanie Iwas  20a. Method of Disposition  ▼\$\sqrt{y}\text{Burial} 2 \sqrt{Cremation} 3	kiw/wife	6342 ce of Dispos netery, crem	g Address (Street and Number of Beachwood Dresition (Name of altory or other place)	. Colum	bia, Md. 2 20c. Location - City or	1046 Town, State
Baltimore,	permit. Page Department of Important: If eny injury or once.		XXBurial 2 Cremation 3 4 Donation 5 Other (Spec	en Spe	22.	Name and Address of Facility	itako En	Suitland, neral Hom	T
ě	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a.  Due to (or as a consequence)  Due to (or as a consequence)	nce of):	THE mode of dying, such as car INFARCE, DY	diac or respiratory ai	rest,	Approximate Interval Between Onset and Death
-	cate be executed physician and the burial-transit	cal	that initiated events resulting in death) Last	c	nce of):				
. DOX	that the death certificate bed by the attending physic detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal di 4 □ Pregnant at time of deal 9 □ Unknown	eath 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of deli	very Day Year
	The law requires that the ite has been signed by thoage 2 should be detached.	þ	Part II. Other significant conditions	REMAR FAILUR	2(-			obacco use contribute to 'es 2 □ No 3 □ Pro	
		Completed	SCAFERE P	PERIPHERAL VI	ATCUL	AR DIVEASE	24a. Was autop perfor 1 - Yes		topsy findings available ompletion of cause of
) I (	ysician: The is certificate director, pag	Be c	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Impatient 2 ☐ EF			Death (Check only o		
	두 두 =	atlon; To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigati	28a. Date of Injury (Month, Day Year)	3b. Time of Injury	28c. Injury at Work?  M 1 Yes 2 No		ence 6 Other (Spec ow injury occurred	ify)
	To the Hospital or Attending Is within 24 hours affer death. To the Euneral Director: Affer completely filled in by the funer.	Certification	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	building, etc. (Specify)			City or Tow		
	ne Hosp n 24 hou ne Fune detely fil	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	hysician: To the best of my knowle miner: On the basis of examination and manner stated.	edge, death n and/or invi	occurred at the time, date and plestigation, in my opinion, death o	ace, and due to the courred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)
1	0	Me	29b. Signature and title of certifier	tram as		29c. License number		April 14	
	10		30. Name and address of person who EDMUHO C		3a) (Type, P			BALT. M	
1	Sta Registr	-	31. Date filed (Month, Day, Year) APR 2 3 2004	32. Registrar's Signatur	9	20 1			

			1. For Amend Item 10f p	State of Maryla per FH,0830,04/2	and / Depa 3/04dhb <i>ei</i>	artment o <i>tificate</i> d	of Health and I Tof Death	Mental Hyg	iene g. No. 200	4 12622
	Physic		1. Decedent's Name (First, Middle, Las		Jones			2. Date of Deat Month		
	/Med Exami		4a. Fecility Name (If not institution, give		CtR.		m, or Location of Death		4c. County of D	eeth
	Funeral Director		217-01-0000		rs. last birthday) P3 Yrs.	If Under 1 You Months Da	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day,	9.1	Birthplece (State or Foreign Country)  ARYLAND
	Maryland -f ahow	tor	Usual Residence of Decedent  10a. State 10b. County  M.D. HARFO		City, Town or Lo	. 1				10d. Inside City Limits 1 ☐ Yes 2 No
	th with the Mi 23a or 28a-f.	Funeral Director	10e. Street and Number	PEET	1500	10f. Zip Coo	de 21014	10	0g. Citizen of What	•
3	ltams	by Funera	11. Marital Status  1. Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	1	Vas Decedent Yes, specify (	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specity:	pecify Yes or No- p Rican, etc.)		merican Indian,
137	within 72 hours affigure.  within 72 hours affigure.  then "naturel", or then in the built or th	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	(Give	lent's Usual Oc kind of work do DO NOT use re	one during most of work	king	16b. Kind of Busine	
	Nore, Maryland 21215-0- ges 1 and 2 should be filed within 72 ha to 1 Health and Mental Hygiene. If I lem 27 Is marked other than "natu or other treumatic avent, the Madical	To Be Col	17. Father's Name (First, Middle, Last)	05	YORG	mar	18. Mother's Nam	ne (First, Middle, N	ANCHOR /	Motive Freigh
	Baltimore, Maryland 2 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If Item 27 is marked other any injury or other treumatic avent. Ill and once.		19a. Informant's Name/Relationship (T	ype, Print) Z-Nephew	19b. Mailin	g Address (Str	reet and Number or Rui	rai Route Number, Bel Ai	City or Town, State	2/0/4
4/11	attimore, mit. Pages 1 ar partment of Hea portant: If Item y injury or other		20a. Method of Disposition  1	Removal from State	Place of Dispose cemetery, crem	A Ceine	place) le14 4-5	4-04 E	SALTIMO	RE, MD.
	Depart Depart Import any inj		21. Signature of Funeral Service Licens	Laurotin	EU	ANS FI	Idress of Facility BAC UNERALCHI	APEL 88	OOHARE	CADRD.
•	Physician /Medical		23a. Part 1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Fina disease or condition resulting in death)	a. Due to (or as a conse	hy	the mode of	dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
866 A	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	equence of):					
416066	D& / DU, ficate be executed physician and s the burial-transit	dical E	(	Due to (or as a conse	equence or):					
•	death certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗆	Ectopic pregna Other (specify,			23d. Date of d Month	elivery Day Year
₹ .	E 9 5	þ	Part II. Other significant conditions co	entributing to death but not re	esulting in the un	derlying cause	given in Part I.		acco use contribute	to the cause of death?  Probably 4 Unknown
William		Completed	Coronary.	artery o	lisee	use		24a. Was an autopsy perform	ed? prior to	autopsy findings available o completion of cause of
3	OI VICA Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?	Hospital: 1 Phopatient 2[	☐ ER/Outpatient	3□ DOA	Other	h <i>(Check only one</i>	) nce 6 □Other (Sp	ecifu)
	T the state of the		27. Manner of Death  162 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. lr		28d. Describe how		ecity)
CONES,	in Diffe	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Spec	cify)			City or Town,	State)	Rural Route Number,
17	tha Hospitel hin 24 hours tha Funeral I	edicai	one)	rsician: To the best of my kr iner: On the basis of examin and manner stated.	nowledge, death nation and/or inve	occurred at the estigation, in m	e time, date and place, by opinion, death occurr	and due to the cau red at the time, dat	use(s) and manner a ee and place, and du	as stated. ue to the cause(s)
	With To I	Σ	29b. Signature and title of certifier	77			ense number	290	d. Date signed (Mor	nth, Day, Year)
6	10		30. Name and address of person who co	ompleted cause of death (Ite	1			a secre	Tredical	Contr
6	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 3 2004	32. Registrar's Sign		books	bel Air	1700	J'and	21014

			ANAL STATE OF THE	artment of Health and Menta rtificate of Death	al Hygiene Reg. No. 2004 12623
	Physici	an	1. Decedent's Name (First, Middle, Last)	Mo	ate of Death onth Day Yeer 3. Time of Death
	/Medio		4. 5. 30. 11. 20. 11. 12. 11. 11. 11. 11. 11. 11. 11. 11	4b. City, Town, or Location of Deeth	PRIL 21 2004 /5:35 P M 4c. County of Death
	Lxaiiii	iei	Union Memorial Hospital	Baltimore	N/A
4	Funeral Director		5. Social Security Number 165-20-5455  1 M 2 F  7. Age (In yrs. last birthday) 77  Yrs.  Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. B. Da Months Days Hours Min. Sept	ste of Birth onth, Dey, Yeer)  9. Birthplece (State or Foreign Country)  tember 1, 1926  Pennsylvania
	he Maryland 8a-f show culfied at	ector	10a. State 10b. County 10c. City, Town or Lo		10d. Inside City Limits 1 🗆 Yes 2 📉 No
	with the	I Dir	10e. Street and Number 6913 Chambers Road	10f. Zip Code 21234	10g. Citizen of What Country?  USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic svent, the Medical Examiner must be notified at once.	by Funeral Director	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican,     □ Yes 2 No Specify:	es or No- 14. Race - American Indian.
21215-0036	within 72 ho ene. than *natur he Meutical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
nd 21	be filed wil Ital Hygien Id other the svent, the	Ве Соп	17. Father's Name (First, Middle, Last)		State of Maryland  Middle, Meiden Sumame)
Maryland	should to nd Ment marked	P	oosepii kowiak	Mary Surgent	
	1 and 2 s Health an em 27 ls r kher traur		84	Chambers Road Baltimore sistion (Name of Date	Maryland 21234  20c. Location - City or Town, State
Baltimore,	Pages ment of ant: If It ury or o		1 Burial 2 Cremation 3 Removal from State	natory or other place)	B 3.4
Balt	permit. Departm Imports eny inju		21. Signature of Funeral Service Licensee Christina L. Milton 22 Christma K. Hilton 5.	er the mode of dying, such as cardiac or respire	e Maryland 21214
8760,	Physician /Medical Examiner prusition and the prusitions it is prusitional to the prusition and the pr	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Congestive he Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ant failure coronary and	Approximate Interval Between Onset and Death  4 days  4 disease 20 years
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 4 □ Pregnant at time of death 5 □	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I. 23	e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 No 3 □ Probably 4 □ Unknown
I Records,		Completed	cardiogenic shock		a. Was an autopsy autopsy performed? death?  Yes 25No 124b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Vital	ysician: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	
Division of	유 등 교	ıtlon: To	1 ☐ Yes 2 ☐ No  27. Menner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation  1 ☐ Accident   Pending   Accident   Acciden		☐ Residence 6 ☐ Other (Specify) scribe how injury occurred
Divisi	al or Attendi s after death if Director: A ad in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	eet, factory, office 28f. Loc	cation (Street and Number or Rural Route Number, v or Town, State)
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (	29a. Certifier (Check only one)  1 [V Certifying Physician: To the best of my knowledge, death 2   Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place, and due estigation, in my opinion, death occurred at the	to the cause(s) and manner as stated.  e time, date and place, and due to the cause(s)
	To 1 To 1	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	8		Real Coare Mr Medical A Handing of 30. Name and address of person who completed cause of death (Item 23a) (Type, 1		
77)	Sta		31. Date filed (Month Day, Year) 32. Registrar's Signature	650 Isaltimore, man	yland 21218
	Registr	ar	31. Date filed (Month Cay, Year) 2004 32. Registrar's Signature	- 60	

ORIGINAL

			1 For State	State of Mar		artment of I	Health and M			12621
			Registrar  1. Decedent's Name (First, Middle, Las	<i>t</i> )		Tillicale of	Dealli	Reg. 2. Date of Death	No. 4 0 0 4	3. Time of Death
	Physici	an	Timbo	0 1/	27eVi	ch		Month	Day Year	MS3 AM
	/Medi		4a. Facility Name (If not institution, give		- 2001	4b City Town	or Location of Death	Aprila	4c. County of Death	CO33 14
	Examir	er		ins Bay		Ball	or Eucation of Death		D 11.	nove
	Funeral		5. Social Security Number 6. Se	,	In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Q Right	place (State or Foreign
Ç,	Director			¥M 2□F	81 Yrs.	Months Days	Hours Min.	Month, Dey, Ye Aug. 11, 1	922 Mars	yland
	D		Usuel Residence of Decedent						, , , , , , , , , , , , , , , , , , ,	zana
	rytan how		10a. State 10b. County	1	IOc. City, Town or L	ocation				10d. Inside City Limits
	B Ma	cto	MD Balti	more		Ва	ltimore			1 ☐ Yes 2X☐ No
	or 26	Oire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cour	ntry?
	23a	by Funeral Director	8029 Gough Str	eet			21221	US	SA .	
	tame	une	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of I	Hispanic Origin? (Spo pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	or l	<u>F</u>	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □XYes 2 □ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		SpecifyWhit	:e
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or itama 23a or 28a-1 show ant, the Medical Examene must be notified at	b b	15. Decedent's Edi	Year or Dates:	160 Door	edent's Usual Occu		105		
15	in 72	Completed	(Specify only highest grad	de completed)	(Give	kind of work done  DO NOT use retire	during most of worki	ng 180	. Kind of Business/In	bustry
12	withi ene. ther	E C	Elementary/Secondary (0-12)	College (1-4or 5+)			Foreman	P	eth Stee	<u> </u>
	Hyg Hyg other ant,		17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Maid	den Sumame)	
au	id be ental ked ic ev	To Be	Michael Kneze	evich			Caroli	ne Wrigh	t	
Maryland	shou ind M i mar umat	۲	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mail	ing Address (Street	t and Number or Rura			Code)
	alth a		Dorothy Knezev:	ich /wife	802	9 Gough	Street :	Baltimor	e MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itama 23a or 28a-f show any injury or other traumatic event, the Medical Exampler in ust by notified at ODGe.		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other pla	ice)		Location - City or To	
Ĕ	Page nent int: #		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 14 ☐ Donation 5 ☐ Other (Specify,			wnĆemet	ery   4/2	3/04 Ba	ltimore	MD
alti	permit. Departn Imports any inju		21. Signature of Funeral Service Licens	see /	11 2	2. Name and Addre	ess of Facility Cor	nellyFu	neral Hom	eofEssex
<u>m</u>	8988		R. Leur	1 Conn	elly	300 Mac	ce Ave. I	Baltimor	e MD 212	201ESSEX
P			23a. Part1. Enter the disease, or company shock, or heart failure. List only	lications that caused the cause on each line.	e death. Lo not en	ter the mode of dyi	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	COCONAC	M AV.	tery v	Disease	2		Onset and Death
×	/Medical		resulting in death)	Due to (or as a	consequence of):					
	Examiner		Sequentially list conditions.	b. Dias	ele '					
	De sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that partially account to the control of the con	Due to (or as a o	consequence of):					
	and -tran	кат	that initiated events resulting in death) Last	c. The totol as a	consequence of):	>				
8760,	cate be executed physician and the burial-transit	al E		DO ON	Consequence bi).	•				
87	icate be executed physician and s the burial-transit	dicai		d. N. (101)	Fally	r				
×	that the death certified by the attending detached for use as	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy				and Base of deliver	
Вох	atten for u	cian	in the past 12 months?	1☐Live birth 2   4☐Pregnant at tin	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of delive Month	Day Year
o.	the d	ıysi	1  Yes 2  No 9  Unknown	9□ Unknown	or dought of					
<b>a</b>	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	by Physician/Me	Part II. Dther significant conditions co	ntributing to death but i	not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
Records,	puires n sigr ald be							1 🗆 Yes	2 No 3 Prob	ably 4 Onknown
Ö	w requires been si should b	Completed						24a. Was an	24b Were auto	nsv findings available
Re	he lav e has	щ				<u> </u>		autopsy performed	death?	psy findings available appletion of cause of
Vital	ician: Th certificate rector, pag		25. Was case referred to medical				00 Pl 4 P 4	1 Yes 2 4	√o 1 ☐ Yes	2,2 No
5	aicia s cert firect	o Be	examiner?	Hospital: 1  Inpatient	2 EN/Outpatie	nt 3 DOA Oth	26. Place of Death		C [[0]	
ō	Physe er this eral dir	-	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injur	ry at 2	8d. Describe how in	6 ☐Other (Specify	7
0	Attending Physician: Ir death. ector: After this certific. by the funeral director.	atlo	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Y	ear) Injury	M 1 🗆	rk? ]Yes 2 ☐No			
Division of	or Attend after death Director: / in by the f	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury	- At home, farm, st	reet, factory, office	2	8f. Location (Street	and Number or Rura	Route Number,
	s afte of Dir	Certification;	7 I Hornicido	building, etc. (	эрөспу)			City or Town, Sta	170)	
	Hospital or A     La hours after     Funeral Dire etely filled in by	cal	29a. Certifier Certifying Phy (Check only 2 Medical Exami	sician: To the best of r	ny knowledge, deal	h occurred at the til	me, date and place, a	nd due to the cause	(s) and manner as st	ated.
	To the Hospital or Attending Physician: The within 24 Hours after dash.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical	une,	ner: On the basis of ex and manner state	d.	vestigation, in my o	pinion, death occurre	ou at the time, date a	ind place, and due to	tne cause(s)
1	To the within To the comple	Σ	29b. Signature and title of certifier			29c. Licens	se number	29d. [	Date signed (Month, L	Jey, Year)
,	X		12 N	1.0.		RES	-000	Hop	1/21.2	2004
	4		30. Name and address of person who co	ompleted cause of deat	th (Item 23a) (Type,	Print)	- 1160 /	?	0 11	
-0	\ <i>I</i>		31. Date filed (Month, Day, Year)	HOCKIN S		dical lent	er 4940 8	aser t	my, seiltin	rore, Marylar
100 m	Sta	te	on Date med (Month, Day, Tear)	oz. negistrar s	L	1				222

	Physicia /Medic	al	Registrer     Decedent's Name (First, Middle, Last)     As. Eacility Name (If not institution, give s	Mary I			r Location of Dea	2. Date of Dea	Reg. No. 200	3. Time of Death 8:35 p.m.
	Examin Funeral Director	er	5. Social Security Number 6. Sex 494-12-1403	e Hospital 7. Age (In yrs. II	-	K05	Hours Min	8. Date of Birth	Ba H	Birthplace (State or Foreign Country) issouri
ne Maryland	Ba-f show ciffied at	ector	Usual Residence of Decedent		, Town or L		Essex		10- 00	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
h with t	23a or 2 at be n	al Dire	10e. Street and Number 42 Ridgemoor F	Road		10f. Zip Code 21	221		10g. Citizen of Wha USA	it Country?
d E.E.SOOOO	if Health and Mental Hygiene. item 27 is marked other than "natural", or Itame 23s or 28s-f ehow other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married XXMarried  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	dispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Black, \ Specify: W	American Indian, White, etc. Ihite
within 72 ho	ene. than 'natur he Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of we	orking		ess/Industry Ore County Education
should be filed	and Mental Hygiene. Is marked other than sumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last)	Davis				th R. Re		
	27 is mar r traumar		19a. Informant's Name/Relationship (Type James Lee Jr.		1				r, City or Town, Sta nroe MD	
Pages 1 a	Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐ Re 1√3 Donation 5 ☐ Other (Specify)	.,	metery, cre	osition (Name of matory or other pla Cemeter	y 4	Date / 24 / 04	20c. Location - City Baltimo	
Daltillo	Departn Imports any Inju		21. Signature of Funeral Service License	of Connect	10 × 2	2. Name and Addre	ess of Facility Co ace Ave	onnellyE e. Balti	FuneralH imore MD	lomeofEssex
,	hysician /Medical xaminer		23a. Pan1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	pulsons that caused the death of cause on each line.  Meta Star  Due to (or as a consequ	tic	1	ng, such as cardia	ic or respiratory ari	rest,	Approximate Interval Between Onset and Death
ficate be executed	(A) -	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
The law requires that the death certificate	been signed by the attending physhould be detached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Bc. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3[	□Ectopic pregnanc □ Other (specify) _	у		23d. Date o Month	f delivery Day Year
wrequires that	been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not resu	ilting in the u	underlying cause giv	ven in Part I.	23e. Did to	·/	te to the cause of death?  Probably 4 Unknown
	ite has page 2	Completed						24a. Was a autop: perfor 1 Yes	sy prior dear	e autopsy findings available r to completion of cause of th? Yes 2 \( \square\) No
VILCUI.	s certifi irector	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 Inpatient 2 🗆	ER/Outpatie	nt 3 DOA Ot	ac.	eath (Check only or Home 5 ☐ Resid	ne) lence 6 □Other(	Specify)
	h. After this funeral o	H- 1	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju			ow injury occurred	Geodity
DIVISION	within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
Hoepi	24 hour Funer letely fille	edical	29a. Certifier 11 Certifying Physical (Check only one) 2 Medical Examin	ician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, dear ion and/or in	th occurred at the travestigation, in my o	me, date and place opinion, death occ	e, and due to the durred at the time, o	cause(s) and manne date and place, and	er as stated. due to the cause(s)
Toth	within To the	Me	29b. Signature and title of certifier	A		29c Licens	0000	$\cap$	29d. Date signed (A	104
	aj.		30. Name and address of person who co	mplet cause of death (Item	23a) (Type	Print)	Δ.	2 :		nd. 21237

DHMH T/ HeV 1/2001

			For	Please	State of M		d / Depa	artmer	nt of H	lealth and	*		9		10	c 0 c
			1 - State Registrar				Cei	rtifica	te of i	Death		Reg. No	. 200		16	bet
	Physicia /Medic		1. Decedent's Nam Frances	e (First, Middle, L M. Luca:							2. Date of D Month April	Da 17	, 2004	ar	. Time of I 4:15	A <sub>M</sub>
	Examin		4a. Facility Name (	If not institution, g	ive street and number)	)		4b. City	, Town, o	Location of Dea	th	4c	. County of D	eath		
					ng Center				OWNSV	rille If Under 24 Hrs			nne Ar			
	Funeral Director		5. Social Security N 212-26-3	3207	Sex 7. Ag 1  M 2  F	85	ast birthday) Yrs.	Months		Hours Min		8, Year)	919 M	Country)	o (State or and	roreign
5			Usual Residence o	f Decedeni 10b. County		10c. City	, Town or Lo	calion						10d.	Inside Cit	y Limits
April	o a	ō	MD	Anne A	rundel	C	ownsv	illo							1 🗌 Yes	2 No
tho di	288	Director	10e. Street and Nu		ranaci		LOWIDV		p Code			10g. Cit	tizen of Whal			21
diam'r.	98 9	0	1454 Fa:	irfield :	Loop Rd.				21032				USA			
000	138	Funeral	11. Marital Status		12. Was Decedent Armed Forces		S. 13.	Was Dece	edent of H	ispanic Origin? ( an, Mexican, Pue	Specify Yes or N	lo-	14. Race - A	merican I	ndian,	
Source affect	perint. Tays: I aid. 2 should be write mining in the last of each min to may and perint. Tays: I aid a should like a should be should like a s	by	1 ☐ Never Man 3 🎇 Widowed	ried 2 Married 4 Divorced			,	1 ☐ Yes		Specify:			Specify: W		<u> </u>	
2 2	netu	eted	(Spe	15. Decedent's city only highest of	Education grade completed)		16a. Dece (Give	kind of w	ork done	during most of we	orking	16b. K	and of Busine	ss/indust	ry	
LIKIO 70	hen.	Completed	Elementary/Sec		College (1-4or	5+)		DO NOT		1)						
1 7	tygie ther t		17. Father's Name	(First Middle La	st)		Homen	naker		18. Mother's Na	ame (First, Middi	e, Maider	Own Ho	me		
Dig Po	ntai h	Be c								Alice			,			
<b>y</b>	mark mark	To	19a. Informant's N	A Dooc lame/Relationship	_		19b. Maili	ng Addres	s (Street	and Number or F		ber, City	or Town, State	e, Zip Co	de)	
Man	ith ar 27 in r frau		Mary McI	ellan -	daughter		101 0	Chesa	peak	e Mobile	, Hanove	er, M	ID 210	076		
ָר בֿ בּ	tam tam otha		20a. Method of Dis			20b. P	lace of Dispo	osition (Na matory or	other place	(a)	Date	20c. L	ocation - City	or Town,	Slate	
	nent cause ant: if ary or			5 Other (Spe	□Removal from State cify)	_	timore				2/04	Lau	rel, M	1D		
	Departi Importa any inj		21. Signature of F	uneral Service Lic	censee Coma		Ga	ary L	. Kar	ss of Facility ufman Fungton Bl	neral H	ome@M	leadowr	idge		inc.
τ	*		23a. Part1. Enter	the disease, or co	omplications that cause by one cause on each	d the death	n. Do not en	ler the mo	de ol dyir	ig, such as cardia	ac or respiratory	arrest,		Ap	proximate erval Betw	
P	hysician		Immediate Cause disease or conditi	(Final			TIF								set and D	
	/Medical		resulting in death)	4	Due to (or as			•								
E.	xaminer		Sequentially list of	onditions.	b. ALZ	-HE	IME	-12'	5							
7	sit a	ine	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated events	mmediate erlying r injury	Due to (or as	s a consequ	Jence of):									
	sician and burial-transit	Examiner	that initiated event resulting in death)	3	c Due to (or as	s a consequ	uence of):									
	Sician Sician Solution	ä			d											
0	eath cerminate us attending physical for use as the b	ledic														
ל ה	endin r use	an/N	IF FEMALE: 23b. Was deceded		23c. If yes, outcome 1 ☐ Live birth			⊒Ectopic i	pregnancy	,			23d. Date of Month	delivery Day	, ,	'ear
	The law requires that the useful selfillicate ite has been signed by the attending physicage 2 should be detached for use as the	by Physician/Medic	in the past 12 1 ☐ Yes 2 9 ☐ Unknow	□No	4□Pregnant a 9□ Unknown	at time of de	eath 5	Other (s	specify) _				WORTH	Day	'	bai
	ed by the a	Phy			s contributing to death	bul not resi	ulting in the u	ınderivina	causa div	en in Part I.	23e. Dio	lobacco	use contribute	e lo the c	ause of de	eath?
necords,	w requires many to be signed to should be det			ATRIA	L FIBR			N	3		1 [	Yes 2	ØN₀ 3□	] Probably	4 □U	nknown
5	been	ete									24a. W8	s an	24b. Were	autopsy	lindings a	vailable
ב ב	nysician: The law his certificate has b il director, page 2 s	Completed									per	opsy formed? 2 No	death	to comple 1? Yes 2⊡	etion of ca	use of
		Be C	25. Was case refe	erred to medical						26. Place of De	1 ☐ Yes eath (Check only			163 2	3140	
>	this cer al direc	To B	examiner?	Mo	Hospital: 1   Inpat	ient 2 🗆	ER/Outpatie	nI 3 🗆 🗆	Oth	er: 4 Nursing	Home 5 ☐ Re	sidence	6 Other (S	Specify)		
<b>S</b>	3 ~ C		27. Manner of Dea	ath 5 Pending	28a. Date of Inj (Month, D	ury a <i>y Year)</i>	28b. Time o Injury	ol	28c. Injur Wor		28d. Describe	how inju	ry occurred			
2	eath. or: A	catio	2 🗀 Accident	investiga 6 ☐ Could no	the -			М		Yes 2 □No		10				
	after d Direct d in by	Certification:	3 ☐ Suicide 4 ☐ Homicide	determin	ad   200. Place of It	njury - At ho elc. <i>(Specif</i> )	ome, larm, st	reet, facto	ry, office		28f. Location City or T	(Street ar own, State	nd Number or e)	r Hural Ho	oute Numi	) <b>0</b> 7,
	in the hospital or Attenting Priystcam, the hospital of the Funeral Director. After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)		Physician: To the bestaminer: On the basis and manner s	of examina										
	withir To th comp	Me	29b. Signature an	d title of certifier				2	9c. Licens	e number		29d. Da	ate signed (Me	onth, Day	, Year)	
ľ			> Cill	ller -	Jun m	>			D2	3450		7	-19-	-07		
	1		30. Name and add	dress of person w	no completed cause of	death (Item	23a) (Type	Print)	C. LL	LA H	40ES	M	> 2/	082	/	
	Sta	ate	31. Date liled (Mo		32. Regis	trar's Signa	ture	/		- 1						
	Regist		APR 2	3 2004	Denice		de	out.	1							

			. For					artment of H			-		gible.	
			State Registrar				Cei	tificate of	Death			Reg. No. 2	001	12627
	Physicia	an	Decedent's Name (First, Middle, L.	i						2	2. Date of Dea Month	Day	Year	2:45 PM
	/Medic	al	4a. Facility Name (If not institution, gi	ve street and				4b. City, Town, or	r Location of I	Death	7	15 4c. Cou	of Deat	
1	Examin	er	Battimore Rehabild			rendea	A.Cork	Certer	3100	1	Saltim	e mr	212	N/A
	Funeral		Social Security Number 6.	Sex 1 M M 2□	7. Ag	e (In yrs. la	ist birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8 Min.		Year)	9. Birt	hplace (State or Foreign
	Director		215-24-1472 Usuat Residence of Decedent	X ** 2	'	75	Yrs.				MAR.27	,1929		MD MD
	yland yland		10a. State 10b. County			10c. City	, Town or Lo	cation						10d. Inside City Limits
	Be-f st	ctor	MD BAL	TIMORE	:		OWI	NGS MILLS						1 Tyes 2 No
	with th	Dire	10e. Street and Number	חמב חו	TVE	<b>#124</b>		10f. Zip Code	2111	7		10g. Citizen		S.A.
	ns 23	Funeral Director	104 PLEASANT RI  11. Marital Status	12. Was	Decedent	Ever in U.S	3. 13.	Was Decedent of H if Yes, specify Cuba	2111 Ispanic Origin		fy Yes or No-	14.1	Race - Ame	ncan Indian,
9	after o	Fun	1 ☐ Never Married 2 ☐ Married		d Forces?	No WWI	I	if Yes, specify Cuba 1 □ Yes 2 1 No	an, Mexican, I Specify:	Puerto H	can, etc.)		Black, White ec <i>ify:</i>	e, etc. WHITE
215-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28e-f show solical Exporter mast be notified at	d by	3 Widowed 4 Divorced	Year	or Dates:	KORE	A						of Business/	
15-	c	Completed	15. Decedent's I (Specify only highest g	ade comple		5)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most o d)	of working	,	100, Killa C	n Dusiness	muustry
212	d within giene.	mo	Elementary/Secondary (0-12)	Colle	ge (1-4or	2	MAN	AGER				JOSEI	PH A.	BANKS
	should be filed within a Mental Hygiene. marked other than imatic event, ITEM.	Be	17. Father's Name (First, Middle, Las	t)				DEDMAN			First, Middle,	Maiden Sur	name)	CAUDED
Maryland	should be nd Mental marked o	ဥ	LOUIS  19a. Informant's Name/Relationship	(Type Print	)			BERMAN	ANN and Number		Route Numbe	r. City or To	wn. State. 2	SAUBER Zip Code) 21117
Ma	2 8 8		AUDREY LIEBERMA		, [FE		T.							MILLS, MD
re,	of Health of Health fitem 27 i	11.2	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3		rom State	1 00	ace of Dispo emetery, crei	esition (Name of matory or other place	ce)	Da	te	20c. Locati	on - City or	Town, State
altimore,	nit. Page artment o ortent: If injury or 8.		`4 ☐ Donation 5 ☐ Other (Spec	ify)		MD		ANS CEMET						ILLS, MD
Balt	permit. Pages 1 a Department of Hes Importent: If item any injury or othe		21. Signature of Buneral Service Lic	ensee Q	All	7		2. Name and Addre						, INC. , MD_21208
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	nplications t y one cause	hat cause on each I	d the death ine.	. Do not en	er the mode of dyir	ng, such as ca	ardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Pro	tated		anul						months
	Examiner				e to (or as	a consequ	ience or):							-
1	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D. ————————————————————————————————————	e to (or as	a consequ	iones of):							
VI	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	e to (or as	a consequ	ence of):		_					0)-
760,	icate be executed physician and s the burial-transit	alE				,								
99	certificate Iding phys	ledic	1											
Box	eath certificate attending phys for use as the	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 🗀 I	ive birth	of pregnal	death 3	⊒Ectopic pregnancy	y			23d.	Date of dea	livery Day Year
	0 0	Physician/Medi	1 Yes 2 No		Pregnant a Jnknown	t time of de	ath 5[	Other (specify) _						,
P.0	The law requires that the d te has been signed by the age 2 should be detached	y Ph	Part II. Other significant conditions	contributing	to death l	out not resu	ılting in the u	inderlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
rds	w requires been sign should be	ed by									101	es 25Ñ	o 3∐Pr	robably 4 □Unknown
ဓင္ပဝ	law re as ber	Completed								_	24a. Was autop	sv	prior to	utopsy findings available completion of cause of
E B											1 Yes		death? 1 ☐ Yes	2 □ No
Vit.	sicier certif irector	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	1 🗆 Innati	ient 2 🗆	ER/Outpatie	nt 3 DOA Oth			<i>(Check only o</i> e 5 ☐ Resid		Other (Spe	cify)
οt	Attending Physicien: r death. ector: After this certification of the funeral director.	<del> </del>	27. Manner of Death	28a.	Date of Inj	ury	28b. Time o		The Report Co. (1) (1)	-	d. Describe I			,,
sior	Attending death. ctor: After y the funer	catlo	Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	on				M 1 🗆	Yes 2 □ No					(C) 1 M - 1 - 1
Division of Vital Records,	l or Attendated after death Director:	Certification:	4 Homicide determine	d 289.		ijury - At ho tc. <i>(Specif</i> y		reet, factory, office		28	City or Tox	vn, State)	umber or Hi	ural Route Number,
_	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one)  Certifying 2 Medical Ex	aminer: On	o the besi the basis manner s	of examinat	wledge, deal tion and/or in	th occurred at the till evestigation, in my o	me, date and opinion, death	place, ar occurred	nd due to the	cause(s) and date and pla	d manner as ice, and due	s stated. a to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier	1	-	M	۵.	29c. Licens	se number	35		29d. Date si	gned (Mont	h, Day, Year)
•	10		30. Name and address of person wh					Print)	,				1 - (	
	$\psi$					trar's Signa		en Blud	Balt.	mor	MO.	212	18	
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 3 20	1	Sz. Hegis		4	1	4					
	3		N: 11 20 ZU	27	100	-	1	pour			· · · · · · · · · · · · · · · · · · ·			

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F <i>rtificate of</i>	lealth and I <i>Death</i>	Mental Hyg	iene 200L	12628
	Physici		1. Decedent's Name (First, Middle, L John Todd McLane	-				2. Date of Deat	th Day Year 22, 2004	3. Time of Death
S.	/Medic Examir		4a. Facility Name (If not institution, ga	ive street and number)		4b. City, Town, o	r Location of Death	1 -	4c. County of Dea	10:12 p <sup>M</sup>
	Funeral				ge (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	Parkvill   If Under 24 Hrs.   Hours   Min.	8. Date of Birth	Year) Co	hplace (State or Foreign
	Director		Usual Residence of Decedent					Sep 14,	, 1925 Pe	nnsylvania
	death with the Maryland ms 23a or 28e-f show rmest be rediffed at	ō	MD Baltim	ore	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28e-	Director	10e. Street and Number		Talkviii	10f. Zip Code		11	0g. Citizen of What Co	ountry?
	ath wit	rai D	8810 Walther Blv	d., Apt N1		21234			United Sta	ites
980	2 should be filed within 72 hours after death with the Marylan and Mantal Hygiene. Is marked other then "nature!, or items 23a or 28e-1 show aumaite event, the Medical Examinar must be rediffed at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	e, etc.
20	72 ho natur	eted	15. Decedent's 1 (Specify only highest g	Education rade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	kina	16b. Kind of Business/	Industry
Maryland 21215-0036	within iene. then '	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	DO NOT use retired icist	1)		Department Navv	of the
DQ .	al Hyg I other vent, I	BeC	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	ne (First, Middle, A		
yla	Ment Ment Markec Markec	T <sub>O</sub>	George Peter Mc					Walsh		
2	nd 2 st lith and 27 Is r r traur		19a. Informant's Name/Relationship Mr. John Todd Mc						City or Town, State, 2 York, NY 1	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Other (Spec	☐Removal from State	20b. Place of Dispo cemetery, cres	osition (Name of matory or other place ake Crema	:e)	Apr 24	20c. Location - City or Beltsville	Town, State
Balt	permit. Departr Importa		21. Signature of Funeral Service Lice	mo mo	0980 2	2. Name and Address Cremation 8717 Gree	n and Fun	eral Alt	ernatives Baltimor	e MD
	Medical Examiner bursician and bursician and street burial-transit	ai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Figury that initiated events resulting in death) Last	a Due to (or as b Due to (or as c.	a consequence of):  a consequence of):	trà				Interval Batween Onset and Death
.O. Box 68/60	death certif e attending id for use as	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	∃Ectopic pregnancy ∃ Other (specify)		-	23d. Date of deli Month	very Day Year
ds, r	w requires that the de been signed by the should be detached		Part II. Other significant conditions		ut not resulting in the u		en in Part I.		acco use contribute to s 2 □ No 3 □ Pro	the cause of death?
Hecords,	us or ca	Completed		Υ		ac b		24a. Was an autopsy perform	prior to death?	topsy findings available ompletion of cause of
VITal	icien: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Othe		h (Check only one	)	
lon or	To the Hospital or Attending Physicien: The I within 2 House after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	ation; To	1 Yes 2 No  27. Mann leath 1 atural 5 Pending 2 Accident investigated	28a. Date of Injui (Month, Day	ent 2 ER/Outpatier ry 28b. Time of y Year) Injury	f 28c. Injun Worl	4 Avursing Ho	ome 5 Resider 28d. Describe hov	nce 6 □Other (Spec w injury occurred	ify)
DIVISION	tal or Atters a strangers after desemblers birectored in by the	Certification:	3 Suicide 6 Could not determined		ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru. State)	ral Route Number,
	the Hospi in 24 hour the Funer optetely fill	edicai	one) 2 Medical Exe	hysicien: To the best of miner: On the basis of and manner sta	f examination and/or in	vestigation, in my or	oinion, death occur	red at the time, da	te and place, and due	to the cause(s)
	2 1 2 10	Σ	29b. Signature and title of certifier	20	(m)	29c. \(\)icense	4242	29	d. Date signed (Month	, Day, Year)
	21		30. Name and address of person who	completed cause of d	leath (Item 23a) (Type)	Pankuz	lled	12 212	.34	
	Sta Registr		31. Date filed (Month, Day, Year)  APD 2 3 2004		ar's Signature	books			,	

				State of Maryla	-	artment of F <i>rtificate of</i>			giene Reg. No. 2 ()	INL 12620
	Blancia		1. Decedent's Neme (First, Middle, Las	it)				2. Date of Dea	ath	3. Time of Death
	Physic /Medi		Estella G.	Mc Crac	1			Month O 4	Day	Year 10:50 Pm
1	Exami		4a. Facility Name (If not institution, give Riverview Care Ce		•		4b. City, Town, or L Essex	ocation of Death		
I	Funeral, Director		5. Social Security Number 6. Social Security Number 1. 6. Social Security	ex 7. Age (In y) □м 2⊠F 98	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 31	v. Year) , 1905	9. Birthplace (State or Foreign Country) Vest Virginia
	pu 🗼		Usual Residence of Decedent  10a. State 10b. County	140	Ob. T					
	e-f shov	ctor	Maryland Baltimor		City, Town or Lo Essex	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 1008 George Avenu	e		10f. Zip Code 21221			10g. Citizen of V USA	-
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or items 23a or 28e-f show any injury or other treumatic event, the Mcdical Examinating the Incitited at once.	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2½ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		e - American Indian, k, White, etc. : White
21215-0020	l within 72 hc iene. then "netur ihe Wedcal	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de com <i>pleted)</i> College (1-4or 5+)		dent's Usual Occup kind of work done DO NOT use retired MSTYESS	ation during most of work f)	ing	16b. Kind of Bu	ing
b	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Lest)				18. Mother's Nam	e (First, Middle,		
ylaı	Menta Menta arked atic e	10	Arthur Poling				Myra Fi	nchan		
Maryland	2 sho		19a. Informant's Name/Relationship (T	,, , , , , , , , , , , , , , , , , , , ,			and Number or Rui			
	1 and Health em 27		Werton Reggles McC  20a. Method of Disposition		Place of Dispo:	sition (Name of	enue Bali	Date Date		∠ I City or Town, State
Baltimore,	. Pages tment of tant: If it jury or o		1 A Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	Removal from State )	cemetery, crem	natory or other place. 1 Mem. G	ardens 4			nore, Maryland
Bal	Depart Depart Import any in		21. Signature of Funeral Service Licens	urkourko-	ss of Facility i Funera. astern Av	l Home F venue Es	A. sex, Md	. 21221		
			23a. Part . Enter the disease, or comp shock, or heart failure. List only o	lications that caused the de ine cause on each line.						Approximate Interval Between
>	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Cerelro			i'dent			Onset and Death
	_ +	ner		Due to	(or as a consequ	uence of):				
ó	executed an and hal-trans	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	(ur as a culisequ	uerice ofj.		·		
k 68760,	eath certificate be executed attending physician and for use es the bunal-transit		resulting in death) Last		(or as a consequ	uence of):			-	
Вох	attend after us	cian/		d				72-1-		
P.O.	res that the de signed by the a be detached t	Physician/N	Part II. Other significant conditions con	ntributing to death but not re			en in Part I.			tribute to the ceuse of death? 3 ☐ Probably 4 ☐ Unknown
of Vital Records,	requir	Completed by	Ostcopororis					24a. Was a	n autopsy ned?	24b. Were autopsy findings available prior to completion of cause
Re	The law ate has page 2	mo	Stoheiner D.	scare. Her	natenois	102'6		1 □ Ye	s 2ENo	of déath? 1 □ Yes 2 □ No
/ita	icien: The	Bec	25. Was case referred to medical		[30(.c.	-	26. Place of Death			
of <	Physicien: r this certific and director,	၉	1 ☐ Yes 2 ☑ 1√0	lospital: 1 ☐ Inpetient 2	1		4 Liprursing Ho			
ion	After fune	ation:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ \	at ? ′es 2 □ No	28d. Describe ho	w injury occurre	d
Division	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec		et, factory, office	:	28f. Location (St. City or Town	reet <b>e</b> nd Numbe , State)	r or Rural Route Number,
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 ☐ Certifying Physical Check only one) 2 ☐ Medical Exemination	sicien: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deeth ation and/or inve	occurred at the time estigation, in my op	e, date and place, a inion, death occurr	and due to the ca ad at the time, da	use(s) and man ate and place, er	ner as stated. nd due to the ceuse(s)
	withi To tt	Σ	29b. Signature and title of certifier			29c. License		29	d. Date signed	(Month, Day, Yeer)
	10		. 144	Some			3667	6	4-23-	2064.
•	Ψ		30. Name end eddress of person who co							
	Sta	te	Michael Schwartz M 31. Date filed (Month, Day, Yeer)	1.D. /310 Rite 32. Registrar's Sign	CN1e Hwy nature	7. Glen B	urnie, Mo	. 21061		
	Registra	ar	31. Date filed (Month, Day, Yeer)	Senera	6 1	20 1				

DHMH 16 Rev 6/95

			State of Maryland / Dep Ce		lental Hygier	
Physic /Med		1. Decedent's Name (First, Middle, Last) Charles	Matth	nai	April 21,	2004 3. Time of Death 7: 25 A M
Exam Funera Directo	ıl	4e. Fecility Name (If not institution, give st 3013 Ritchie Avenue 5. Social Security Number 6. Sex 220–22–5120		Sparrows Point	8. Date of Birth (Month, Day, Yes January 18,	Baltimore  9. Birthplace (State or Foreign Country)
pu ≱		Usual Residence of Decedent  10a. State  10b. County  MD. Baltimore	10c. City, Town or L Sparrows		ocurring 10,	10d. Inside City Limits 1 🗀 Yes 2 🏋 No
h with the 23e or 28e	Funeral Director	10e. Street and Number 3013 Ritchie Avenue		10f. Zip Code 21219		Citizen of What Country?
72 hours after death with the M natural; or Items 23s or 28s-f	þ	1 ☐ Never Married 2 ☐ Married 3 € Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces?  ↑♥ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 8 years	Completed) (Give life.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) ne Operator	ing	Kind of Business/Industry Steel
d tab	To Be (	George C. Matthai	- Ocital 10h Mail	18. Mother's Nam  Mary M.  ling Address (Street and Number or Rur		
2 DEN 2		19a. Informant's Name/Relationship (Typ Nancy Matthai Dat 20a. Method of Disposition 1 Burial 2XX remation 3 Re	aghter-In-Law 3013	Ritchie Avenue, S	Sparrows P	
permit. Pages 1 an Department of Heal Important: if Item 2 any njury or other	SUCE.	21. Signature of Funeral Service License	Bayview C	crematory or other place) Crematory 2002 22. Name and Address of Facility Connelly Funeral Ho 7110 Sollers Point	ome Of DUn	ltimore City,MD. dalk,P.a. dalk,Md. 21222
Physicia /Medica Examine	al	23a. Pert1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not er expected by the cause on each line.  BLALN  Due to (or as a consequence of):	meter the mode of dying, such as cardiac Metasta  A Cung C	or respiratory arrest,	Approximate Interval Between
cate be executed physician and the burial-transit	dical Examiner		Due to (or as a consequence of):  Due to (or as a consequence of):			
COIdS, F.O. BOX 6001  M requires that the death certificate been signed by the attending phys should be detached for use as the	hysician/Medi	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
wrequires that the been signed by the should be detached.	by P	Part II. Other significant conditions conf	ributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
The lay ate has page 2	Completed					24b. Were autopsy findings available prior to completion of cause of death?  No 1 \subseteq Yes 2 \subseteq No
on c	ation: To Be	examiner?	ospital: 1 Inpatient 2 ER/Outpatie  28a. Date of Injury (Month, Day Year)  28b. Time Injury	ent 3 DOA Other: 4 Nursing Ho	h (Check only one) ome 5 A esidence 28d. Describe how in	6 [Other (Specify)
DIVISION (itel or Attending Furs after death. rat Director: After fled in by the funeral funer	Certification:		28e. Place of Injury - At home, farm, s building, etc. (Specify)	7.4	City or Town, St	<u>~_</u>
DIVISICA  To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	ician: To the best of my knowledge, dea er: On the basis of examination and/or i and manner stated.		red at the time, date :	
1	0	30 Name and address of person who con	mpleted cause of death (Item 23a) (Type	D 3904	Han	pril 22,2004 over street
Regi	State strar		32. Registrar's Signature	baltomo	re n	10 2/22

MHW			1 For Unpend Item 1 Registrar	#23a,Stater	Mary	andos Pres Ce	rtificate of	lealth ar Death	nd Mental H	lygien		12631
			Decedent's Name (First, Middle	, Last)		_			2. Date of	Death		3. Time of Death
	Physici /Medic		Cornelius			Marshal	1		APRI	L 18,		11:20 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution	-	umber)		4b. City, Town, o		Death	40	. County of Death	
S			UPPER CHESAPEA		CAL CEN		BELAII		III -		HARFORI	
S	Funeral		5. Social Security Number 054–42–4926	6. Sex 1 M 2 F		vrs. last birthday) Yrs.	If Under 1 Year Months Days		Min. (Month,	Day, Year	Cou	
W	Director		Usual Residence of Decedent	Λ	52	110.			11-	18–51	Md	•
	faryland show		10a. State 10b. County		10c.	City, Town or Lo	ocation					10d. Inside City Limits
	Mary safe	tor	Md. Harf	ord		Edge	hoow					1 X Yes 2 No
	th the M or 28a-f	jre	10e. Street and Number		•		10f. Zip Code			10g. C	itizen of What Cou	ntry?
	ath wi	rai	2115 Trimble R	d.			21040				USA	
	items items	une	11. Marital Status	Armed F		n U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origir an, Mexican, I	n? (Specify Yes or Puerto Rican, etc.)	No-	<ol> <li>Race - Ameri Black, White,</li> </ol>	
36	rs aft	by Funeral Director	1 Never Married 2 Marr 3 Widowed 4 Divorced	if Yes, G Year or [	2 No ive Dates:		1 ☐ Yes 2 ☐ No	Specify:			Specify: B	lack
0	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent. Le Medical Eraminer must be molified at		15. Decedent	's Education		16a. Dece	dent's Usual Occup	ation		16b. F	Cind of Business/In	dustry
215	hin 72 an "na	ple	(Specify only highes Elementary/Secondary (0-12)		) (1-4or 5+)		kind of work done of DO NOT use retired	,	f working			
213	e filed withir al Hygiene. other than vent.	Completed	GED		,	Sel	f Employe	ed 		Ice	Cream S	nack Truck
P	be file tal Hy d oth	Be	17. Father's Name (First, Middle,	Last)					s Name (First, Midd	dle, Maidei	,	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shoi other traumatic event. The Medical Exartiner must be notified at	2	Cornelius	in Constitution	Marsh	nall, Sr	<del>-</del>		Deloris		Hill	
<u>a</u>	d 2 st th and 7 is n traun		19a. Informant's Name/Relations!  Teah Marshall		life		ng Address (Street:  5 Trimble			_		Code)
_	s 1 and 2 of Health item 27 i		20a. Method of Disposition	V		b. Place of Dispo	sition (Name of		Date		21040 ocation - City or To	own, State
Baltimore,	ages ant of it: If it		1  Burial 2  Cremation 4  Donation 5  Other (S)	3 Removal from	State	-	matory or other place Mem. Par		-24-04		rbutus Me	
謹	artme ortan injur		21. Signature Funeral Service	• •		T	2. Name and Addres	,				
ñ	permit. Pages 1 a Department of He Important: if item any injury or othe		Munko	G		M	arch F.H.	East	1101 E	. Nor	e, Md. : th Ave.	21202
			23a. Part1. Enter the disease, or shock, or heart failure. List	omplications that	caused the d	leath. Do not ent	er the mode of dyin	g, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
	Physician	0 1	Immediate Cause (Final disease or condition			al Hemorri	nage					Onset and Death
	/Medical		resulting in death)	a		sequence of):						
	Examiner	L	Sequentially list conditions,	b	<b></b>							
	ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (blassas or injury that initiated events	Due to	(Or as a cons	sequence of):						
	sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a cons	sequence of):						
8760,	ate be executed physician and the burial-transit	dical		d.								
9	tificate ng phys as the	ledi							Aleman			_
XO	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	utcome of pre birth 2 □ F		Ectopic pregnancy				23d. Date of delive	·
Э. В	ne deat the att hed fo	sicla	in the past 12 months? 1 Yes 2 No		nant at time of		Other (specify)				Month	Day Year
Division of Vital Records, P.O. Box	that the de ed by the detached	Completed by Physiclan/Med	9 Unknown  Part II. Other significant condition	and contributing to a	death but not	reculting in the u	ndarhina anusa siyu	on in Port I	23a Di	d tobacco	use contribute to th	ne cause of death?
s,	w requires that s been signed t s should be det	l by		_	Jean Dui not	resulting in the d	nderlying cause givi	en in Fanti,			□No 3□Prot	
ore.	requ been shouk	etec	Chronic Drug Abuse						-			
Rec	The lav	ldmi							, pe	topsy rformed?	prior to co- death?	psy findings available impletion of cause of
ā	ician: Th certificate rector, pag	S	25. Was case referred to medical		-			26 Place of	1 Da Yes Death (Check onl	2 No	1 X Yes	2 No
>	ysicie s cert direct	To Be	examiner? 1 XYes 2 ☐ No	Hospital:	Inpatient 2	2 ER/Outpatier	nt 3 DOA Othe		ng Home 5 Re		6 □Other (Specif	v)
0	tending Physician: leath. tor: After this certific the funeral director,	n: T	27. Manner of Death	28a. Date	of Injury oth, Day Year			at k?	28d. Describ			
10	endin sath. or: Af he fur	atlc	1 Natural 5 Pendin 2 Accident investig	pation	,, , , ,	,,,		Yes 2□No				
<u>×</u>	al or Attendir : after death. I Director: Af d in by the fu	Certification;	3 Suicide 6 Could r 4 Homicide determ	and 200. Place	e of Injury - A ling, etc. (Spe	At home, farm, str ec <i>ify)</i>	eet, factory, office		28f. Location City or 7	(Street ar	nd Number or Rura a)	d Route Number,
Δ	Hospital or Attending Physician: The law requires that the death certific 44 hours after death. Funeral Director: After this certificate has been signed by the attending p fulled in by the funeral director, page 2 should be detached for use as								<u> </u>			
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by the	Medical	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the Examiner: On the t and man	e best of my to basis of examiner stated.	Knowledge, death nination and/or in	n occurred at the time vestigation, in my of	ne, date and p pinion, death	place, and due to the occurred at the time	e cause(s e, date and	) and manner as si d place, and due to	tated. the cause(s)
	within 2 To the comple	Me	29b. Signature and title of certifier		mor stated.		29c. License	e number		29d. Da	te signed (Month,	Day, Year)
	► S ⊢ Ö		I hig hi	. m.D	•		0	СМЕ		AP	RIL 19, 2	2004
			30. Name and address of person			Item 23a) (Type,						2007
	200		LING L				111	Penn S	treet, Ba	altim	ore, Mary	yland 21201
	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Si	gnature						
	Registr	ar	APR 2 3 2	UU4	CARD S	J. 628						

other than "netural", or items 23e or 28a-1 show and, the Medical Example to confine at a completed by Funeral Director	4a. Face 5. Societ 174 Usual F 10a. St. P 10e. St. 217 11. Mai	ERLE  Lity Name (If  Tok  A Security Nu  -24-34  desidence of I  ate  A  seet and Num  S. Ma  ital Status  Never Marrie	mber 6 13 Decedent 10b. County Cambr	jive street and nu Pkin5 Sex 134M 2□F	7. Age (In yrs. I 7.5		4b. City, To	Himos	ation of Death	2. Date of 0	Day	County	Z 00 <sup>1</sup> of Death	3. Time of	
ner than "netural", or liems 23e or 28e-f show and it the Medical Examination and installed at completed by Funeral Director	5. Social 174 Usual F 10a. St. P 10e. St. 217 11. Mar 1 1 3	Lesidence of late A  S. Maital Status  Never Marrie	mber 6 13 Decedent 10b. County  Cambr	Prins Sex 1⊅M 2□F	7. Age (In yrs. I 7.5	ast birthday) Yrs.	Ba I	Himos	. 1	- <b>u</b>	40.				
ner than "netural", or items 23e or 28e-f show it, the Medical Evaluation Lines for cutified at Completed by Funeral Director	Usual F 10a. St. P 10e. St. 217 11. Mar 1 3	A  S. Ma ital Status  Never Marrie	Decedent 10b. County  Cambr ber		10c. City	, Town or Lo			Jnder 24 Hrs. ours Min.	8. Date of E (Month, 1	Day, Year)	N/A			or Foreig
it, the Man	217 11. Mar 1	S . Maital Status  Never Marrie	ber			Eh 1				02/06/	1929		- 11	0d. Inside C	
it, the Man			ed 2⊠Marrie	12. Was Dec Armed F d 1 Tyes If Yes, G	2 □ No ive		10f. Zip Ci	nt of Hispar Cuban, M	15931 nic Origin? (S exican, Puert	pecify Yes or I o Rican, etc.)		<u>U:</u>	k, White,	ean Indian, etc.	
	Elem		15. Decedent's fy onfy highest	grade completed,		(Give life.	dent's Usual C kind of work DO NOT use	done durin retired)	g most of wor	king			isiness/In	,	
7 is marked off traumatic even To Be	A1b	ert S.	First, Middle, La  Maurey  me/Relationship	7		19b. Mailii	ng Address (S		Floren	ne (First, Midd Ce Long tral Route Nurr	we11	Sumam	е)		
f item 27 Is r other trau	Har 20a. M	riet Method of Dispo	Staurey/Vosition	Vife    Removal from		217 lace of Dispo	S. Mala osition (Name matory or othe	ion S	Street	Ebens	burg,	PA cation -	City or To	own, State	
Importent: I any injury o once.			5 Other (Speneral Service Li		Ho1	St		Address of Ashi	Facility Scl	3/2004 nwab Fu <u>Balti</u>	neral	Hor		nc.	
hysician and importantial transit aurial-transit au	Immediseas resulting Sequentiany, cause. Cause that intresulting	art1. Enter th ock, or hear iate Cause (f e or condition g in death)  ntially list con eading to im Enter Under (Disease or i iated events g in death) L	t failure. List or Final Inditions, mediate tying	b. Pa	caused the death each line.  Cumonic (or as a consequence of consequence) (or as a consequence) (or as a consequence)	uence of): Couence of).	a ucer	of dying, su	ch as cardiac	or respiratory	arrest,			Approximation interval Bet Onset and Z Of	ween Death
d by the attending physicis etached for use as the but etached for use as the but but but but but but but but but but		IALE: las decedent the past 12 r Yes 2 C Unknown	months?	1 ☐ Live	utcome of pregna birth 2 Fetal mant at time of de nown	death 3	□Ectopic preg □ Other (spec		(======================================			3d. Dat Mor	e of delive		Year
be od	Partii.	Other signifi	cant condition	s contributing to	death but not resu	ulting in the u	inderlying cau	se given in	Part I.	1[	Yes 2	×40	3 🗍 Prob		Jnknow
dificate has or, page 2	25. Wa		ed to medical					26.	Place of Dea		opsy formed? 22 No	-	rior to co leath?	psy findings mpletion of c 2□ No	ause of
al dii	1 [	miner? Yes 2 noer of Death Natural Accident	5 🗋 Pending investiga	28a. Date (Moi		ER/Outpatier 28b. Time o Injury		Other: 4 Injury at Work? 1  Yes		ome 5 Re 28d. Describ				y)	
2 9			6 Could no determin	ed 286. Place build	e of Injury - At ho ding, etc. (Specify se best of my kno	viedge, deat	h occurred at	the time, d	ate and place	, and due to th	own, State,	and ma	nner as s	ated.	
To the Funeral Di		nne)	2 Medical E	kaminer: On the	basis of examinal nner stated.	tion and/or in	ivestigation, in	i my opinio	n, death occu	rred at the time	e, date and	place, a	and due to	Day, Year)	) 

DHMH 17 Rev 1/2001

ORIGINAL

				1 - For State Registrar			d / Depa	artmen	t of H		and M	ental Hyg	iene <sub>eg. No.</sub> 2 (	004	4 Counts	633
		Physici		1. Decedent's Name (First, Middle, Dusty Claire Ma									13 <sup>0ay</sup> 200	) 4 <sup>ear</sup>	3. Time of 1620	Death M
		/Medic Examin		4a. Facility Name (If not institution, Upper Chesapeal			r		Town, or	Location o	of Death		4c. Count	y of Death arfor		
		Funeral Director		5. Social Security Number 020-62-1886 Usual Residence of Decedent	6. Sex 1 □ M 2 □ F	7. Age (In yrs. 64	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth Feb. 2,	<sup>4</sup> 1940	9. Birth Cou Mas	place (State o ntry) sachus	r Foreign etts
		yłand how		10a. State 10b. County		10c. Cit	y, Town or Lo								10d. Inside Ci	-
		ith the Mar or 28a-fs	Director	Md. Harfo	ord		Bel.		0.4				0.00	14#	1 🗆 Yes	2 <b>X</b> ]No
		3a or 3		10e. Street and Number 504 New Place (	Court			10f. Zip	1014	+			Og. Citizen of Unite	d Sta	tes.	
	920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "naturel", or Items 23a or 28e-f show or other traumatic event, the Medical Exartinar must be muitified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☑ Widowed 4 □ Divorced	Armed Fo	2 🔯 No ∕e		Was Deced f Yes, spec		ispanic Ori in, Mexicar Specify:		ocity Yes or No- Rican, etc.)		ck, White,	can Indian, etc. hite	
0	15-0	"natur	leted	15. Decedent (Specify only highes	s Education grade completed)		16a. Deced	dent's Usua kind of wo	al Occupa	ation during mosi	t of workii	ng	16b. Kind of B	lusiness/In	dustry	
e	altimore, Maryland 21215-0036	2 should be filed withir and Mental Hyglene. Is marked other than aumatic event, ILE M	Completed	Elementary/Secondary (0-12) 12 years	College (1	1-4or 5+)		emake					own h	ome		
	and	be file ntal Hy ed othe event	Be	17. Father's Name (First, Middle, L	ast)							(First, Middle, I				
	aryk	should ind Men s marke umatic	T <sub>O</sub>	John Hamlin 19a. Informant's Name/Relationsh	ip (Турв, Print)		19b. Mailir	ng Address	(Street a			Route Number	·		Code)	
101	Š,	1 and 2 Health a tem 27 Is		Fred Matthews,	Jr./son	205 5						Bel Air,				
40/81/14	nore	ages 1 int of H t: If ite y or otl		20a. Method of Disposition  1 □ Burial 2 ☐ Cremation  4 □ Donation 5 □ Other (Sp.	3 Removal from	State	Place of Dispo cemetery, crer yview				4/15/		20c. Location Baltim			
17	altir	permit. Pages 1 and Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service L		Da	*	Name an	d Addres	ss of Facilit	v	Home c				
	8	88 1 8		23a Part 1 Enter the disease or	omplications that of	anusad the deat	h. Do not ont	610	W. M	lacPha	ail R	Road. Be	1 Air.		21014	
		Pnysician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on e	each line.	achon			g, such as	Cardiac o	respiratory arr	951,		Approximate Interval Bety Onset and D	veen Death
	7	/Medical Examiner		disease or condition resulting in death)	aDue to	trace (or as a conseq	uence of):			4		100		0	KU MC	<u>1065</u>
#334468	3760,		Ical Examiner	Equantially list our ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq		Hy	oer	iten	9101	1			YEAR	
X	.0. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the bural-transit	Completed by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	1 Live b	tcome of pregna pirth 2 ☐ Feta pant at time of d own	Ideath 3[	Ectopic pr Other (sp	egnancy					ate of deliver		'ear
	cords, P.O	aw requires that as been signed I 2 should be det	ed by P	Part II. Other significant condition Hypertension								23e. Did tol	oacco use con		he cause of de pably 4 DU	
osty	II Reco		Complet	Depression,								24a. Was a autops perform	ged?	Were auto prior to co death? 1 🗌 Yes	psy findings a mpletion of ca 2 \( \text{No} \)	available ause of
C	Vita	ysiclen: Th is certificate director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	it 3□ DC	Othe			(Check only on ne 5□ Reside		os (Specif		
ES3	n of	ding Phys n. After this funeral di	on; To	27. Manner of Death  1 Natural 5 Pending	28a. Date	of Injury th, Day Year)	28b. Time of Injury	_	8c. Injury Work	/ at k?		28d. Describe ho			y)	
Thews	Division	Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certificately filled in by the funeral director,	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	of Injury - At h	ome, farm, str	М	10,	Yes 2□	- 1	28f. Location (St City or Town		ber or Rura	al Route Numi	ber,
4	Ö	pitel or urs afte erel Die														
3		To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical 8	Physician: To the examiner: On the b and man	asis of examina	tion and/or in	vestigation	, in my op	pinion, dea	d place, a	ed at the time, d	ate and place,	and due to	the cause(s)	
		To t To t	2	29b. Signature and title of certifier	Jan	2		290	License	591	135	) 2	9d. Date signe APR	Month,	uay, Year) 4 20	07
		6		30. Name and address of person v	vito completed caus	se of death (Iter	n 23a) (Турв,		ko	Driv	۵۱	Bel	die M	D	21014	
		Sta Regist		31. Date filed (Month, Day, Year) APR 2 3 2004		egistrar's Signa	ature Apr	nds	/	VIIV			, , ,			

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H0/E1/17

\* #334469

			For State Registrer	State o	f Maryla		artment of H		ind Mental I	Hygier Reg. 1	Z 11 11 1.	12634
I	Physici	an	1. Decedent's Name (First, Midd Milton		chant				2. Date of Month	Death	Day Yeer 1-2004	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution	n, give street and nur	mber)		4b. City, Town, o				4c. County of Death	
Н	Funeral		Fairhaven Life 5. Social Security Number	e Care Com		. last birthday)	If Under 1 Year	esvill	24 Hrs. 8. Date of	Birth	Carrol 9. Birth	polace (State or Foreign
	Director		147-03-6348	1 <b>∑</b> M 2□F	100	Yrs.	Months Days	Hours	Min. (Month) Dec	$D_{ay}$ , Yes	1903 Mass	sachusettes
	how how		10a. State 10b. County	,	10c. C	ity, Town or Lo	ecation					10d. Inside City Limits
	he Ma 28a-f s	ecto	MD Ca:	rroll		Sykesv	ille			100	Citizen of What Cou	1 □Yes 2 No
	death with the Maryland ms 23a or 28a-f show	i Dir	7200 Third Av	enue Apt.	A-214			1784		109.	USA	may:
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural; or Items 23a or 28a-1 show any Injury or other treumatic event, It is Marical Extendition and be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Mail 3 ☑ Widowed 4 □ Divorced	12. Was Dece Armed For ried 1 17 Yes	edent Ever in l orces? 2 □ No ve τ.π./		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	ispanic Orig in, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amer Black, White Specify: Whi	, etc.
15-0	"netur	leted		nt's Education est grade completed)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most	of working	16b.	Kind of Business/I	ndustry
2121	d within giene. rr than	Completed	Elementary/Secondary (0-12)	College (1	1-4or 5+)		emical E		er		Chemical	
Maryland 21215-0036	12 should be filed within 'n and Mental Hygiene. 7 Is marked other than "Ireumatic event, It a Men	Be	17. Father's Name (First, Middle,	Last) Henry Merc	hant				's Name <i>(First, Mid</i> ia May Ti		len Sumame)	
aryla	should and Me amark umatic	ပ္	19a. Informant's Name/Relation		.IIQIIC	19b. Mailir	ng Address (Street				y or Town, State, Zi	p Code)
	and 2 fealth a m 27 ls		Mr. C. Todd B	rown (Neph			Thornbe	rry C	Ct., Westr	-	er, MD 21	
altimore,	ages 1 ent of F nt: If ite y or ot		20a. Method of Disposition 1		State	cemetery, crer	natory or other place eld Cemete				Location - City or T $_{ m kesville}$ .	
Baltin	permit. P Departmo Importer any Injur		21. Signature of Funeral Service		ist		AIGHT FUI	VERAL		IAPEI	, PA (Box	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that of only one cause on e	aysed the dea		er the mode of dyin	g, such as c	cardiac or respirator		773 1400	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Con	or as a conse		leurt	Fwi	1-12			6 MO
	Examiner		Sequentially list conditions,	b. ———								
K	ted nsit	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conse	quanes of j.						
8760,	ficate be executed physician and s the burial-transit	dicai Examln	resulting in death) Last	C. Due to	(or as a conse	quence of):						
9	artificate ing phy e as the	60	IF FEMALE:	U								
P.O. Box	law requires that the death certificate been signed by the attending to should be detached for use as	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nirth 2□Fet nant at time of	tal death 3 □	Ectopic pregnancy Other (specify)			-	23d. Date of deliv Month	Pery Day Year
	wrequires that been signed b should be deta	ed by Pt	Part II. Other significant condition	ons contributing to di	eath but not re	sulting in the u	nderlying cause give	en in Part I.	A 4.		o use contribute to t	the cause of death?
Division of Vital Records,	The ate has page	Complet			·		·		24a. W ar pr 1 🗆 Ye	itopsy erformed?	prior to co	opsy findings available ompletion of cause of
Vita	alcien: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	☐ ER/Outpatien	Othe		of Death (Check on		2 FOUL (0.11)	
n of	ding Phys h. After this funeral di	on; To	27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. Date		28b. Time of	IL JUDOA	4 MINUT			6 □Other (Special jury occurred	ny)
ivisio	r Attendii ter death. irector: A irey the fu	tification	2 ☐ Accident invest	not be 28e. Place	of Injury - At I	home, farm, str	M 1 □	Yes 2□N	28f. Locatio	n (Street Town, Sta	and Number or Run ate)	al Route Number,
۵	To the Hospital or Attending P within 24 hours atter death. To the Funeral Director: After t completely filled in by the tuneral	Medical Certification;	(Check only 2 Medice	ng Physician: To the Examiner: On the b	asis of examin	nowledge, death	n occurred at the time	ne, date and pinion, death	I place, and due to to	he cause	(s) and manner as s	stated. o the cause(s)
<b>.</b>	To the within 2 To the complete	Med	29b. Signature and title of certific	er	ner stated.	NO	29c. Licenso	number 2P	7 2	29d. [	Date signed (Month	"Day, Year)
	5		30 Name and address of person	who completed caus	se of death (Ite	эт 23а) (Туре,	Print)	-00	///	2	0.1	Secken all
1	)			L. Mo1.	egistrar's Sign	<del></del>	NINEI	, 64	-f N	1,14	V 6'3'	and an educa
	Sta Registi		31. Date filed (Month, Day, Year APR 2 3 20	04 A		Acres	40					

		-	1 - For State Ragistrar	State of Marylar		artment of I rtificate of		ı	Reg. No.	
4	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, La  Willie M  4a. Facility Name (If not institution, give	liller		4b. City, Town, o	or Location of Dea	2. Date of Dea Month	Day Year  2 2 2 2 4c. County of Dec	5:02 PM
	Funeral Director		5. Social Security Number 6. S	7. Åge (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days			h 9. Bi	rthplace (State or Foreign ountry) RYLAND
	e Maryland 3a-f show tillied at	ctor	10a. State 10b. County MD . BALTIM		ty, Town or Lo	ESSEX	ζ			10d. Inside City Limits 1 XYes 2 □ No
	3a or 28	I Director	10e. Street and Number 1606 GAIL RC	AD APT.		10f. Zip Code 2	L221		10g. Citizen of What C	ountry?
036	urs after deatl	by Funeral	11. Marital Status  CON ever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub		(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
9500-91212	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dether than "natural", or items 23a or 28a-f show id other than "natural", or items 23a or 28a-f show event, the Modical Exercit ar must be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 8TH		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w	orking	16b. Kind of Business HOTEL	s/Industry
Maryland	d ta b 💆	To Be C	17. Father's Name (First, Middle, Last WILLIE MILLER,	SR.			BERNI	ame (First, Middle, CE BROW	N	
	1 and 2 sh Health and em 27 is m ther traum		19a. Informant's Name/Relationship ( LISA SMITH (CC  20a. Method of Disposition	USIN)	43'4'	Trimble	e Field		GEWOOD , MI  20c. Location - City o	21040
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		1 △ Burial 2 Cremation 3 C 4 Donation 5 Other (Special Structure of Funeral Service Lices	Removal from State (y) M	cemetery, crei C, CARM	Tatory or other placed in the comment of the commen	TERY A	GGS FUN	004 BALTC	,MD.
<i>y</i> .	805 8 8		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the dea one cause on each line.	1	412 E.	PRESTO	N ST. B	ALTO, MD.	21213 Approximate Interval Between Onset and Death
760,	Physician /Medical Examiner  Wedical physician and physici	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events resulting in death) Last	a. A CONOLIS  Due to (or as a consect  C. Due to (or as a consect  d. William and the	quence of):		len éveltégé g	diada.	é	
.O. Box 68	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3[	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year
٥.	quires that n signed by	by	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.		obacco use contribute	o the cause of death?
al Records,	: The law requires that the cate has been signed by th page 2 should be detache.	Completed						24a. Was autop perfor 1 □ Yes	rmed? prior to	utopsy findings available completion of cause of
Vital	nysician: Th nis certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatier	nt 3□ DOA Ot		eath (Check only o	ne) dence 6 □Other (Spe	acify)
Division of	ting Pt I. After th funeral	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time o Injury	Wo			now injury occurred	
N N	afte Dir	Certification:	3 Suicide 6 Could not be determined	building, etc. (Speci	ify)			City or Tow		
	To the Hospital or within 24 hours afte To the Funeral Direction completely filled in the Funeral Direction of the Funera	Medical	29a. Certifier 1 P Certifying Pl (Check only 2 Medical Examone)	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death oc	ce, and due to the courred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
ı	To th withir To th comp	Me	29b. Signature and title of certifier		_	29c. Licen:	se number		29d. Date signed (Mon	
	1		Den & Red			D53	824		04-22-0	>4
	X		30. Name and address of person who 44 Z6 Park Hei	completed cause of death (Ite	m 23a) (Type,	Print) Teri	Kilhouri 2121	1500, MD		
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	e				

			Please 1  1 - State Registrar	State of Maryla	and / Depa	<b>delible Ink. E</b> artment of Hea rtificate of De	alth and Me	ental Hyg	Are Legible liene <sub>eg. No.</sub>	4 12636
	Physici /Medic		Decedent's Name (First, Middle, Last Ralph Nichols					2. Date of Deat Month April	Day Yea 13 200	04 8:30 PM
	Examir Funeral	ner	4a. Facility Name (If not institution, give Stella Maris  5. Social Security Number  055-16-4838		rs. last birthday) Yrs.		Under 24 Hrs.	8. Date of Birth (Month, Day,	Baltim	Ore Birthplace (State or Foreign Country)
	Director  work 1-8-1  work 1-8-1  med at the particular at the par	ctor	Usuel Residence of Decedent  10a. State 10b. County  Maryland Baltimo:	10c.	City, Town or Lo	cation	D	ecember	18,1914	Massachusett  10d. Inside City Limits 1 □ Yes 2 💆 No
	th with the 23a or 28 ust be no	al Dire	10e. Street and Number 1825 Blue Mt. Rd.			10f. Zip Code 21111		1	Og. Citizen of What United S	
920	within 72 hours after deeth with the Maryland ene. than "natural", or itams 23e or 28e-f show the Medical Examination multiplied at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispa f Yes, specify Cuban, M I ☐ Yes 2XXNo S	nic Origin? (Spec Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	Black, W	mencan Indian, hite, etc. white
Maryland 21215-0036	I within 72 ho jene. r than "natur tha Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	lent's Usual Occupation kind of work done during OO NOT use retired)	n ng most of working	g	16b. Kind of Busine manufact	•
yland 2	should be filed vand Mental Hygie s marked other i umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Robie Nichols			18. Ec	Mother's Name	es	Maiden Sumame)	
	1 and 2 st Health and em 27 is n		19a. Informant's Name/Relationship (Ty Steve Nichols/son 20a. Method of Disposition		325 G	g Address (Street and Lenn Ave.		Island,		01
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examples must be notified at ODEs.		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	G1	reenmoun	t Crematory  Name and Address of Mitchell 6500 Yor	Facility -Wiedefe	5,2004	Baltimore	e, Maryland
,60,	Physician /Medical Examiner physician and physician and physician in the privilege physician physician are provided the physician are physician and physician are physician and physician are physicia	Ilcal Examiner	23a. Part. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that infittated events resulting in death) Last	Due to (or as a cons  Due to (or as a cons  Due to (or as a cons	requence of):	, 2 / 2	activas caldiac of	өзынашу ане		Approximate Interval Between Onset and Death
P.O. Box 6	Physician: The law requires that the death certificate this certificate this certificate by the attending physical director, page 2 should be detached for use as the trail director.	by Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fi 4 □ Pregnant at time o 9 □ Unknown	etel death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
rds, P	quires that in signed b uld be deta		Part II. Other cant conditions cor		resulting in the ur	iderlying cause given in	Part I.			to the cause of death?  Probably 4 Munknown
of Vital Records,	ician: The law requir certificate has been s rector, page 2 should	Completed		hreire				24a. Was ar autopsy perform 1 Yes 2	ed? prior to	autopsy findings available o completion of cause of es 2 \square No
	fter	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	lospital: 1	28b. Time of	28c. Injury at Work?		5 🗆 Resider	n) nce 6 □Other (Sp w injury occurred	ecify)
Division	= = = =	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, stre	eet, factory, office	28	f. Location (Str. City or Town,		Rural Route Number,
	To the Hospitel of within 24 hours at To the Funeral D completely filled in	Medical	one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death ination and/or inv	estigation, in my opinio	n, death occurred	at the time, da	te and place, and di	ue to the cause(s)
	with Con	2	, , ,	od no	-	29c. License nur D15504		29	d. Date signed (Mor	ith, Day, Year)
	\		30. Name and address of person who co Eddie Nakhuda, M.D 31. Date filed (Month, Day, Year)		aney Va	·	Timonium	n, MD 2	21093	
	Sta Registr		APR 2 3 2004	Service .	B A	parks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 0 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** onnson mes /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Health -orest 101 7. Age (In yrs. last birthday).
Yrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours M 2□F 186-05-0323 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City. Town or Location 10b. Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural; or items 23a or 28a-1 show any or other than the neither trial to notified a sury or other transities event, the Musical Engine Baltimore 1 ☐ Yes 2 No Director 10e. Street a 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1/2 Yes 2 □ No W. W. II 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc Specify: White 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Accounting Elementary/Secondary (0-12) ccountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No. Department of Health a Important: If item 27 is any injury or other training one. useph 501 9/1 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License MD: 21093 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Cleant or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the attending physician and ned for use as the burial-transit Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) detached P.O. 9 Unknown ate has been signed by t page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy 2 No 1 Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 🗌 Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number OXI 03229 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. 415 MAC

Registrar

APR 2 3 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Sports

			1 - For Stete Registrar	State of Marylan		artment of He		ental Hygie Reg.	2001	12638
	Physici /Medic Examir	cal	Decedent's Name (First, Middle,     Richard Anders     Anders     Anders     Anders	on Purnell, Jr.		4b. Cily, Town, or Lo	ocation of Death	April 11	Day Year 2004 4c. County of Death	3. Time of Death 9:26 A. M
	Funeral Director		220-40-7946	5. Sex 18≦M 2□F 7. Age (In yrs. 61	last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Oct. 23,19	iar) Cou	plece (State or Foreign intry) h. D.C.
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exertiral must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10e. Street and Number  5107 Maple Park  11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced  15. Decedent's (Specify only highest Elementary/Secondary (0-12)  17. Father's Name (First, Middle, L. Richard A. Pu  19a. Informant's Name/Relationshi  Janet Purnell  20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Specify Specify S	AVenue    12. Was Decedent Ever in U Armed Forces?   1   Yes 2   No If Yes, Give Year or Dates:   Education grade completed   College (1-4 or 5+)   1     Ist)   Trnell, Sr.   (Type, Print)   (Wife)	16a. Decer (Give life.)  Custor  19b. Mailin  510  Place of Disposemetery, creation./Wa	timore  101. Zip Code  21207  Was Decedent of Hisp If Yes, specify Cuban,  1 Yes 2 No  dent's Usual Occupatic kind of work done dur DO NOT use retired)  mer Service  7 Maple Pan sistion (Name of matory or other place) ash. Cremato Characan Address ( Characan A	Specify:  on most of working  e Rep  B. Mother's Name  Jane Herp  d Number or Rural  rk Avenue  tory 4-20  of Facility  rail Home	(First, Middle, Maid Dick  Baltimate 200.)  Of Catons	Citizen of What Cou  U.S.A.  14. Race - Amening Black, White, Specify: White,	ican Indian, , etc.  ite  industry  p Code)  1207  own, State  yland
1,00,	Physician /Medical / Wedical / Italiansit ransit	Ical Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):	er the mode of dying,	such as cardiac or			Approximate Interval Between Onset and Death
O. Box 6	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of di	I death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
cords, P.	iaw requires that the de as been signed by the a 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use of the underlying cause given in Part I.							he cause of death?
Ě	The lay ate has page 2	Completed					<del>/-</del>	24a. Was an autopsy performed?	prior to co	opsy findings available mpletion of cause of 2 No
ision or vital	g Phys er this eral di	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Many of Death  1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no	he	28b. Time of Injury	t 3 DOA Other:  28c, Injury at Work?  M 1 Yes	2 ( No	e 5  Residence		
Š	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	edical	4 Homicide determin  29a. Certifier (Check only one)  1 Certifying 2 Medicel Ex		V) wledge, death	n occurred at the time, restigation, in my opini	date and place, ar on, death occurred	City or Town, Stand due to the caused at the time, date a	(s) and manner as st and place, and due to	tated. o the cause(s)
	C con Take To	W	29b. Signature and title of c. rtifler  30. Name and address of person w	, , , , , , , , , , , , , , , , , , , ,	129a) (Type.	Print)	25234	29d. C	Date signed (Month,	Day, Year) 2004 Dille Maryland 2122/5
1/200	Sta Registr		Robert HMI 31. Date filed (Month, Day, Year) APR 2.3 2004	MlVng 516	ture	ROIING TO	Dad Jv	118 209	Caronso	2127/8

			1 - For State Registrar	State of M		artment of Health and <i>rtificate of Death</i>		ene 2004	12639
	Division		Decedent's Name (First, Middle, Li	ist)		· · · · ·	2. Date of Death Month	Day Year	3. Time of Death
П	Physici /Media		ETHEL	PH	1 PPS		APRIL	19th 2000	100-1
	Examir	ner	4a. Fecility Name (If not institution, gi			4b. City, Town, or Location of De	4	4c. County of Death	
		,	5. Social Security Number 6.		NEKAL Age (In yrs. last birthday)	1000 1 100 1 1000 1 1000	Hrs. 8. Date of Birth	HOWAR 9 Birth	place (State or Foreign
	Funeral Director			1 □ M 2½∏xF	93 Yrs.	Months Days Hours N	Month, Day, 1 Dec 28,	1910 Vir	ginia
	ס		Usuel Residence of Decedent						
	arylar show	Ļ	10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits
	8a-f	Director	MD Howard		Laurel	T. 2 = 2	140		1 ☐ Yes 2 ☐ No XX
	72 hours after death with the Maryland natural', or items 23a or 28a-f show Jical Exarchent ke notified at		10e. Street and Number			10f. Zip Code	100	g. Citizen of What Cou	intry?
	ns 23	Funeral	10914 Hammond Dr	12. Was Deceder	nt Ever in U.S. 13.	20723 Was Decedent of Hispanic Origin?	(Specify Yes or No-	USA 14. Race - Amer	ican Indian.
(0	r Her	돌	1 Never Married 2 Married	Armed Force	s?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	uèrto Rican, etc.)	Black, White	, etc.
e e	ral', o	þ	3 X widowed 4 □ Divorced	If Yes, Give Year or Dates	s:	1 ☐ Yes 2 🖾 🐧 o Specify:		Specify:	White
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or items 23s or 28s-f show of other than "natural", or items 23s or 28s-f show event, it a Madical Existing Instrument by nothing at	Completed	15. Decedent's E (Specify only highest g		16a. Dece (Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working 16	6b. Kind of Business/I	ndustry
121		m	Elementary/Secondary (0-12) Grade 12	College (1-4c	r 5+)			O	
р Б	filed withir Hygiene. other then		17. Father's Name (First, Middle, Las	t)	ног	nemaker	Name (First, Middle, Ma	Own Hom	e
an		To Be	Noah Rush Phipps			Marth	ia Emma Loop	per	
Maryland	d 2 should be f th and Mental H 7 is marked of traumatic ever	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street and Number or			p Code)
	2 = 2 :		Roderic Phipps	/ Grands	on 1091	4 Hammond Drive	Laurel, Ma	aryland 2	0723
ore.	ges 1 and t of Healt If itam 2: or other		20a. Method of Disposition 1 □ Burial 2 ☒ Femation 3 [	Removal from Stat	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date 20	c. Location - City or T	own, State
Ĕ	Pag ment ant: I ury o		'4 □ Donation 5 □ Other (Spec		West Aru		ril 23, (4	Odenton	, MD
Baltimore,	permit. Pages I Department of H Important: If its any injury or ot		21. Signature of Funeral Service Lice		2	2. Name and Address of Facility Donaldson Funera	1 Home, P.A	A .	
_	₹0 E € 0	6 19	(73) - 4n		400770	313 Talbott Aven	ue Laurel	, Maryland	20707
	Physician	, (1 ii)	23a. Pert1. Enter the disease, or cor shock, or heart failure. List ont Immediate Cause (Final disease or condition	one cause on each				it,	Approximate Interval Between Onset and Death
ı	/Medical		resulting in death)	Due to (or a	as a consequence of):	ory falling			2 WEEKS
	Examiner		Sequentially list conditions,	b B1		- LNERWO	AING		
	e ed	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or t	is a consequence of).				
	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or a	as a consequence of):			-	
8760,	be e sician buria	ie H							
687	phy:	edicai		0.				T.	
Box	The faw requires that the death certific ate has been signed by the attending fa page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Testania aragnasa.		23d. Date of deliv	,
	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ NO		at time of death 5	_Ectopic pregnancy _ Other (s <i>pecify)</i>		Month	Day Year
0.0	that the de led by the a detached i	Phys	9 Unknown						
	res tha igned be de	by	Part II. Other significant conditions	contributing to death STRUCTI	0 .		23e. Did toba 1 ☐ Yes	cco use contribute to	
Vital Records,	w require been si should I	Completed	CARENIC OB	3100011	06 1 2.	10.011109		20-1	bably Lounkhown
န္တင	e law has b	mpje					<ul> <li>24a. Was an autopsy performe</li> </ul>	prior to co	opsy findings available impletion of cause of
a			05 116				1□ Yes 2	No 1 ☐ Yes	2□H6
₹	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2	Hospital:	tient 2 ER/Outpatie	Other	Death <i>(Check only one)</i> g Home 5 🗆 Residen	an 6 DOthas (Saas	£.1
ō	g Physier this		27. Manner of Death	28a. Date of Ir	jury 28b. Time o		28d. Describe how		(y)
<u>o</u>	nding lath. r: After e funer	Certification;	1t Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, I	Day Yeer) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	Attender death	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of	Injury - At home, farm, streetc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
Ö	itat or rs aft al Dii	Ce		1	**				
	To the Hospitat or Attending within 24 hours after death.  To the Funaral Director: After completely filled in by the fune.	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exe	hysician: To the be- miner: On the basis and manner	st of my knowledge, deat of examination and/or in stated	h occurred at the time, date and pla vestigation, in my opinion, death o	ace, and due to the cau courred at the time, date	se(s) and manner as s e and place, and due t	stated. o the cause(s)
	ithin 2 o the	Mec	29b. Signature and title of certifier	and manner	siai <del>o</del> u.	29c. License number	290	I. Date signed (Month,	Day, Year)
	⊢≯⊢g		1 Blance	2	MD	D31331			04 2004
	/0		30. Name and address of person who	completed cause o				101101	
	Ψ		MONA SH	ALLICAT	10-202	·	GOGE RI	Cown	1BIA MA
	Sta		31. Date filed MPR 27. 30ac)	32/Regin	strar's Signature	1		,	210UU

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				n ivial yla	•	tificate				Reg. No. 200	4	12640
Physician /Medical		Decedent's Name (First, Middle, La     NETTIE					PENI		2. Date of De Month	19 200		3. Time of Death 8:45 11-7
Examiner								Locetion of Death  IMORE  4c. County of Death			/ A	
Funeral Director		5. Social Security Number 6. 9 6. 9	ID PARK		. last birthday) 94 Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min	8. Date of Bir	oth ey, Year) ,1909		e (State or Foreign
and	- 1-	Usuel Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d	. Inside City Limits
Maryli 1 sho	5	MD N/A			BALTI						"	1 No 2 No
vith the Mar t or 28a-f si be notified	3	10e. Street and Number				10f. Zip	Code			10g. Citizen of Wha	t Country	?
th wit		830 W. 40TH STRE	ET #60	2				21211			U.	S.A.
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other then "neturer; or items 23a or 28a-f show any injury or other treumetic event, the Medical Examinar must be notified at once.  To Be Completed by Funeral Director	2	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Dec Armed F 1 Tes If Yes, G Yeer or D	edent Ever in l prces? 2 <b>M</b> No ve pates:		Vas Decede f Yes, speci i □ Yes 2			Specify Yes or No to Rican, etc.)	5- 14. Race - / Black, V Specify:	Vhite, etc	
Maryland 21215-0020 ad 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other then "neturel; or treumatic event, the Medical Exam To Be Completed by F	nered	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  2 OWNER				rking	16b. Kind of Business/Industry  ANTIQUE SALES		
be filed tal Hygi d other event.	5	17. Father's Name (First, Middle, Lest	)		OWI	VL IX		18. Mother's Ne	me (First, Middle	, Maiden Sumeme)	)/\LL\	,
ylar build be Menta arked artic ev	2	HERMAN			JACOE	38		RAY			ME	EYERS
Mar d 2 shc h end 7 is m	1	19a. Informant's Name/Relationship ( HERBERT MITTENTHA		NI.		_				er, City or Town, Ste N, MD 2120		ode)
Heali Heali tem 2	ŀ	TERDERI 1411 I EN I TH 20a. Method of Disposition	AL / 30	20b.	Plece of Dispo	sition (Nam	ne of		Date	20c. Location - City		, State
Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		State	cemetery, cren TH TFII	-			4/22/04	WOODLA	WN.	MD
Baltimore, permit. Pages 1 an Department of Heal Important if item 2 any Injury or other once.		4 Donation 5 Other (Specify)  BETH TFILOH CEMETERY 4/22/04 WOODLAWN, MD  21. Signature of Funeral Service Licensee  22. Name and Address of Facility SOL LEVINSON & BROS., INC  8900 REISTERSTOWN ROAD - PIKESVILLE, MD 2										INC.
		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications thet	caused the dea	th. Do not ente	er the mode	of dying	, such as cardia	or respiratory a	rrest,	In	oproximate terval Between
Physician /Medical Examiner		Immediate Ceuse (Fin <i>a</i> l disease or condition resulting in death)	a. Lau		VA CAV		om	a vu	lva			re year.
uted Insit			b	2 - 4 - 1	3000 2000	2001						
68760, ifficate be executed g physician and es the buriel-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c		or as a conseq			Al Proposition of the Contract				
- E OO I	-	resulting in death) Last	d	0) 01 600	or as a consequ	dence oi).		<u>-</u>				
• 0 00 0		Part II. Other significant conditione of	ontributing to d	eath but not res	sulting in the ur	nderlying ca	use give	n in Part I.		tobacco use contrib		e ceuse of death?
S, F es tha igned be de by F	1											
aw requii									24a. Was perfo	an autopsy 24 ormed?	availa	autopsy findings ble prior to letion of cause lth?
al H									10	Yes 2 NNo	1 🗆 Y	es 2□ No
f Vital Re system: The last contines to be com		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospitel:	lamati	I CD/Code d	0000	Othe	. /	ath (Check only o			
Physic Prhysic Prthis c eral dire		27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of		A Bc. Injury Work	4 LAP Nursing F		dence 6 Other (5	Specify)	
nding F ath. r: After ne funer		1 Matural 5 Pending 2 Accident investigation	1	th, Day Year)	Injury	М		es 2□No				
Division tallor is effective to the control of the		3 ☐ Suicide 6 ☐ Could not b determined	build	ng, etc. <i>(Speci</i>					City or Tov			
ne Hospitai in 24 hours he Funerai pletely filled		29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exam one)	<b>niner:</b> On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or inv	occurred a estigation, i	it the time in my opi	e, date and place nion, de <i>a</i> th occu	, and due to the rred at the time,	cause(s) and manne date and place, and	r as state due to the	od. e cause(s)
To the within 2 To the comple		29b. Signature end title of certifier  M. Hawellie			ورد درمو		License			29d. Date signed (M Cpul 19		
6		30. Neme end address of person who MISABELLE MA	completed ceu	se of death (Ite	m 23a) (Type, I 3 0 W - 4			·				
State		31. Date filed (Month, Dey, Year) APR 2 3 2004		legistrar's Sign		aks						

A	MEND #23	State of Maryland Bb, Per DR, G830, 4/23/04, CC	d / Department of Certificate of			e 2004	1261.1
		1. Decedent's Name (First, Middle, Last)		2.	Date of Death	ay Year	3. Time of Death
	Physician /Medical	BERTHA ROBISOI	4			7 04	9. 20AM
	Examiner	4a Facility Name (If not institution, give street and number) HOLY CROSS NURSING AND REHAB.		4b. City, Town, or Locat Burtonsvill		c. County of Death	y Co.
ı	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday) If Under 1 Yea Months Days	r If Under 24 Hrs. 8. s Hours Min. A	Date of Birth (Month, Day, Yea	_	lace (State or Foreign
	*	Usual Residence of Decedent		11	PIII IS	1919 Hary.	Land
	Marylan 4 show		r, Town or Location irtonsville			11	0d. Inside City Limits 1 ☐ Yes 2 🎇 No
	recilinating	10e. Street and Number	10f. Zip Code		10g. C	Citizen of What Coun	try?
	th with	15137 Red Cedar Drive	20866		U.	S.A.	
020	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Med cal Eventiner must be notified at empleted by Funeral Director	11. Marital Status  12. Was Decedent Ever in U, Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	S. 13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Specit ban, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Americ Black, White, of Specify: Wh	
5-0	72 hc	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occu (Give kind of work done	upation e duning most of working ed)	16b.	Kind of Business/Ind	ustry
2121	be filed within 72 ho tal Hygiene. to other than "natura event, the Medical Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Tife. DO NOT use retire Homemaker	ed)		Home	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than any injury or other traumetic event, the Monce.  To Be Comp	17. Father's Neme (First, Middle, Last) Johnson Frampton		18. Mother's Name (F		en <i>Sumame)</i> Brandt	
	and 2 short alth and A 27 is mail but traums	19a. Informant's Name/Relationship (Type, Print) Mary N. Larkins (Daughter)	19b. Mailing Address (Street 15137 Red Ced				
Baltimore,	ages 1 gent of He t: if Item y or othy	11 Burial 2 □ Cremation 3 □ Removal from State	ace of Disposition (Name of emetery, crematory or other plants of the Cross Cemet	ace)		Location - City or To	
3altir	oemit. P Departme Importan any injur	21. Signature of Funeral Service Licensee	-	ress of Facility Ly-Polyniak			
	00560	Alorge M. Hamplow,	P₹   130 E.	. Fort Ave.	Baltimor	e, Md. 21	230
	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or			espiratory arrest,	1	Approximate Interval Between Onset and Death
3							
	uted d ansit	0	INFARCTION as a consequence of):				
ó	an and inal-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or	as a consequence or,				
68760,	physician and s the bunder transit s the bundar-transit	Cause (Disease or injury that initiated events resulting in death) Last	as a consequence of):				
Box (	nat tha daath certific d by the attanding p letached for use as Physician/Mer	d					
	na death the atta thed for	Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause g	iven in Part I.	23b. Did tobaco	o use contribute to	the cause of death?
P.0	that tha death certific ed by the attending p detached for use as / Physician/Me				1 🗆 Yes	2⊠ No 3□ Prob	ably 4 Unknown
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requiras that the death certific within 24 hours after death.  To the Funeral Director: After this cartificata has been signed by the attending p complately filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Me				24a. Was an aut performed?	ava	re autopsy findings allable prior to appletion of cause death?
æ	The la				1∃Ves :	- L	Yes 2 No
ital	artifica actor, p	25. Was case referred to medical examiner?		26. Place of Death (C	Check only one)	1	
of V	Physician: this cartificatel director,	1 Yes 2 No Hospital: 1 Inpatient 2 □ I	ER/Outpatient 3LJ DOA			6 □Other (Specify	)
ion	Attending P or death.  Sector: After the funeration:	27. Menner of Death   28a. Date of Injury     1 □ Natural   5 □ Pending   (Month, Day Year)     2 □ Accident   investigation	28b. Time of lnjury 28c. Inju Wo	uryat 28d ork? ]Yes 2 □ No	l. Describe how inj	ury occurred	
Divis	To the Hospital or Attending Physis within 24 hours after death.  To the Funeral Director: After this complately filled in by the funeral director Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office )	28f.	Location (Street a City or Town, Sta	and Number or Rura te)	Route Number,
+	To the Hospital or A within 24 hours after To the Funeral Directomplately filled in by Medical Certif	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know and menner stated.	vledge, deeth occurred et the toon and/or investigation, in my	time, date end plece, and opinion, death occurred o	due to the cause( et the time, date ar	s) and manner es stand place, and due to	ated. the cause(s)
	within To the compl	29b. Signature and title of certifier		nse number	29d. D	ate signed (Month, L	Day, Year)
	/	Maria Holdmarl	\$ 25	348		1/19/04	
	5	30. Name and address of person who completed cause of death (Item Marcia Goldmark 3415	23a) (Type, Print) Greencastle	Rel Burter	prille	md ac	2705
	State Registrar	31. Date filed (Month, Day, Year) 22. Registrar's Signat	*	'			

DHMH 16 Rev 6/95

		ŀ	1 - For State Registrar	State of M	laryland / D	Оера		t of H	ealth a	and N	Mental Hy	giene Reg. No. 2	0	-	642
	Physici /Medic	al	Decedent's Name (First, Middle, Joseph Ralph Re     Aa. Facility Name (If not institution,	ector	-)		4h City	Town or	Location of	of Death	2. Date of De Month April	13, 20	Year 004 unty of Deat	3. Time o	
	Examin Funeral	er	Laurel Regional	Hospital	ge (In yrs. last birt.	hday)	Laur	el 1 Year	If Under	24 Hrs.	8. Date of Bir	Pri	nce Ge	orge's	or Foreign
	Director		218-20-2456 Usuel Residence of Decedent	1 <b>☑</b> M 2□F	70	Yrs.	Months	Days	Hours	Min.	09/10/1	927		yland	
	the Maryla 28a-f shov	ector	10a. State 10b. County Maryland Prince	George's	10c. City, Town	_		Codo				10g. Citizen	of What Co		2 No
	With With	יום היי	804 Fifth Street	. Apt. 3			1	0707	,			USA	OF WHAT CO	uritry :	
9600	be filed within 72 hours after death with the Maryland tial Hygiene. od other then "natural", or Items 23e or 28e-f show event, the Medical Eseriff at final be notified at	d by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4% Divorced	12. Was Deceden Armed Forces d 1 1 Yes 2 If Yes, Give Year or Dates	?  No	1	☐ Yes 2	No No	Specify:	gin? (Sp	ecify Yes or No Rican, etc.)	)- 14. Sp	Black, White ecify: Wh	ite	
1215	within 72 fiene. than "nat	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 11			(Give I lite. E	lent's Usua kind of wor DO NOT us Paint	k done d e retired)	ition uring mosi	t of work	ing		of Business/ n Busi		
Maryland 21215-0036	S should be filed and Mental Hygid Is marked other surmatic event, It	To Be C	17. Father's Name (First, Middle, La Joseph Rector	ast)							e (First, Middle, [orris	Maiden Sur	name)		
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationshi Elaine Rector,				-				al Route Number aure1,				
Baltimore,	Pages 1 and 3 nent of Health nt: If item 27 iry or other tra		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		20b. Place of	Dispos y, crem	sition (Nam natory or of	ne of ther place	9)		Date 1 18, 2	20c. Locati	on - City or		D
Balti	permit. Pages. Department of I Importent: If ite sny injury or of once.		21. Signature of Funeral Service Li		MO1250						eck Fun Rd, Lau		-		07
	Physician /Medical Examiner	_	23a. Part 1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Pulmon Due to (or a	ary Embo	lis of):		e of dying	g, such as	cardiac	or respiratory a	rrest,		Approxima Interval Be Onset and 30 minu	Death
68760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence o										
O. Box	that the death certificate bed by the attending physic detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 □ Fetal death at time of death		Ectopic pre Other (spe					23d.	Date of deli Month		Year
rds, P.	The law requires that the tee has been signed by the bage 2 should be detache	by	Part II. Other significant condition	s contributing to death	but not resulting in	the un	iderlying ca	use give	n in Part I.					the cause of cobably 4	
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Vital	io e de	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2∑No	Hospital:	ATTRO		45.00	Othe			h (Check only o				
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Division	i gitte	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 289. Place of It	njury - At home, far itc. <i>(Specify)</i>	m, stre	eet, factory, office 28f. Location (Stree City or Town, S				amber or Ru	ral Route Num	iber,		
	To the Hospital within 24 hours a To the Funerel Completely filled	edical	(Check only 2 Medical Ex	Physician: To the bes caminer: On the basis and manner s	of examination and	, death Dor inv	estigation,	in my op	inion, deat	d place, th occur	red at the time,	date and plac	ce, and due	to the cause(s	s)
	To the within X	W	29b. Signature and title of certifier	Cell	sh n	址		License D175				29d. Date sig April			
	10.		30. Name and address of person we Rene L. Gelber,					te l	02A I	aure	≘1, Marv	land	20707		
gle	Sta Registr		31. Date filed (Month, Day, Year) APR 2 3 200	82. Regis	rar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 2 per Dr., 0830, 04,28 (William / Department of Health and Mental Hygiene 2000) 1- Rose Amend Item 24a per Verb Certificate of Beath 4dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 04/09/04 Month Scott **Physician** 4:05 PM cuerett Gordon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center Genesis Baltimore Homewood 7. Age (In yrs. last birthday) 35 Yrs. If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 4-23-68 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 12 M 2□F 219-94-1710 Md. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merial Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23e or 28e-f ehow any injury or other traumatte event, the Medical Examination. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Md. Baltimore Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Preston スススタ East U.S. A. 2/2/3 Was Decedent Ever in U.S. Armed Forces 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2☑No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry TULKOFF Elementary/Secondary (0-12) College (1-4or 5+) INC laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) England Nathaniel MOSES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2229 East Presion St (SISTER) Balt. Md. Darlene Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State April 16,2004 Baltimore Md. Woodlawn Lem. 22. Name and Address of Facility

Gry L. Rollins Funeval Home

JID J West Southst Frederick 21. Signatuse of Funeral Service Lices 21701 23a. Part1. Enter the disease, or/com shock, or heart failure. List only Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition **Physician** HULF Imm uno deficiency resulting in death) /Medical Due to (or as a consequence of) Examiner Weight Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed moesophs + burial-tran and Due to (or as a consequence of): of Vital Records, P.O. Box 68760, as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Year 4□Pregnant at time of death 5 Other (specify) should be detached ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? 2█ No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funerel Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/14/4 30115 Ohiokpehal, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21215 sitimore mo AVE 31. Date filed (Month, Day, Year) APR 2 3 2004 oains 132. Registrar's Signature State Registrar

		Dhysisi		1 - State Amend Item 23b, pt.II, 25, 27, 28 C fri Peatener 683 h1-18	2. Date of D		3. Time of Death
		Physici /Medio		Earl Shipley	Apri	1	004 1139 AM
		Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat	th	4c. County	
				5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs	8 Date of Bi	NA	
	Н	Funeral Director		214-44-9228 X M 2□F 57 Yrs. Months Days Hours Min.		ay, Year)	Birthplace (State or Foreign Country)  Md
1				Usual Residence of Decedent	0-0-1	340	<u>nu</u>
Shipler		arylar ahow	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
5		Ba-f	ecto	Md N/A Balto			<b>X</b> □Yes 2 □ No
35		with t	ā	10e. Street and Number 10f. Zip Code		10g. Citizen of V	,
_		filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23e or 28e-f ahow that the Modical Examiner must be rigitled at	Funeral Director	1645 N. Benta1ou Street 21216  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or N	U S A	e - American Indian,
8	ယ	or Iter	Έ	Armed Forces? If Yes, specify Cuban, Mexican, Puent 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ※☐ No	to Rican, etc.)	Blac	k, White, etc.
11)	5-0036	ral', o	l by	If Yes, Give 1 ☐ Yes 2 ★No Specify:		Specify	Black
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Knawn	Maryland	d ta b	To Be	11111	t Jacks		e)
7,2	Ž	SEE	F	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			State. Zio Code)
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alient	Baltimore,	S - = 0	1 8	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location -	City or Town, State
3	imo	Page nent o ant: If ary or		i M buriai 2 Cremation 3 Chemoval from State	-2004	Randa1	1stown, Md
00	alti	permit. Pag Department Importent: I any injury o		21. Signature of Figure 1 Service Lickness of Facility		F/H Wes	t
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	Ш			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	c or respiratory a	ırrest,	Approximate Interval Between
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	XO	leath certifica attending ph I for use as th	Physician/Med	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			of delivery
		ed fo	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Mon	th Day Year
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U	Ś,	ires tha signed b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			bute to the cause of death?  3 Probably 4 Munknown
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1	3ec	elaw hast	mpl	Bowel obstruction; seizure disorder	24a. Was	psy pi	Vere autopsy findings available for to completion of cause of eath?
13		ilcian: The l certificate ha rector, page			1 Ves	2 □ No 1	Yes 2 No
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B	of	Phys er this eral di	T: To	27. Manner of Death 28a. Date of Injury 28b. Time of 11nk-28c. Injury at		dence 6 Othe	( ) //
K	Division	nding th. r: Afte	atloi	1 ★ Natural 5 Pending (Month, Day Year) Injury Work? 2 ★ Accident investigation August 9,2002		st seizu	
	Vis	acto by th	iffica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (	Street and Numbe	r or Rural Route Number unk
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		To the Hospital or Attending Pl within 24 hours after death. To the Funaral Diractor: After the completaly filled in by the funera	dical	29a. Certifier (Check only)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	, and due to the	cause(s) and man	ner as stated.
		the H in 24 the F the F	a a	and manner stated.	med at the time,		
		or twitter	Σ	29b. Signature and title of certifier  29c. License number		29d. Date signed	(Month, Day, Year)
_				1000	0	April 1	7 2004
	,	4		no blanch address of severe who appelled a constitution of death (Non-100-) (Total District			
	,	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 R = 1	100000	
		4	to.	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mark Claryh; MD Sina; Itosphol o  31. Date filed (Month, Day, Year)  32. Registrar's Signature	L Ball	Lmore	
		Sta Registr		Mark Clavyh, MD Sina, Itosphal o  31. Date filed (Month, Day, Year)  APR 2 3 2004	L Ball	Lomore	

	State of Maryland / Department of Health and Mental Hygiene Certificate of Death  State Registrar  Certificate of Death  Reg. No. 2004 12645
	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death
Physician /Medical	Donald Edward Smith April 20, 7004 11:00 PM
Examiner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Sinai Hospital of Baltimore Baltimore City  5 Social Security Number   6 Sex   7 Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   8 Date of Birth   9 Birtholace (State or Foreign
Funeral Director	1 M 2 F - Vrs Months Days Hours Min. (Month, Day, Year) Country)
	Usual Residence of Decedent
arylan ahow	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 11 ✓ 11 ✓ 19c. City Town or Location 11 ✓ 11 ✓ 19c. City Town or Location 11 ✓ 19c. City Town or Location 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 11 ✓ 19c. City Town or Location 10d. Inside City Limits 10d. Inside City
with the Ma	Md N/A Balto
a or 2	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  3610 W. Forest Park Avenue 21216 U.S. A
5 uffer death v r items 23a diret must.	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
or iter	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No
5-0036 72 hours after death with the Maryland natural; or items 23a or 28a-f show aleal Examinent must be notified at seed by Funeral Director	
21215-00 ed within 72 hou within 72 hou set than "naturation in the modeled it, the Modeled Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry  16c. Cocient Cocumators
withii withii them	Elementary/Secondary (0·12)   College (1·4or 5+)   Social Security
Ind 2 tell Hyg d other event,	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
ryland 21. ryland 21. rouid be filed wir for Mental Hygien marked other th metic event, Inc.	Herbert Brown Anna Jenifer
C 8 6 8 1	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  23 Red Jonathan Ct Pikesville 21208
ore, M	Valerie R. Smith - Daughter  20a Method of Disposition
Baltimore, permit. Pages 1 ar Department of Hea Important: If item; any injury or other once.	1 ABurial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  Commetery, crematory or other place)  Garrison Forest Vet 4/26/2004 Owings Mills, Md
ontain Partin	21. Signature of Funeral Service Licensee, 22. Name and Address of Facility March F/H West
Bal Bal Departiment Important Import	4300 Wabsah Avenue Balto, MD 21215
	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between
Physician	Immediate Cause (Final disease or condition ) a PNEU MONICO Onset and Death
/Medical Examiner	resulting in death)  Due to (or as a consequence of):
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b, executed in and inal-transit	cause. Enter Underlying cause (Disease or injury that initiated events  c
O, exec an an an rital-tr	resulting in death) Last Due to (or as a consequence of):
Records, P.O. Box 68760, The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit completed by Physiclan/Medical Examir	d
x 6.	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
Box 68 leath certifica attending ph I for use as ti	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month Day Year
IS, P.O. I	1 Yes 2 No 9 Unknown 9 Unknown
S, P s that so that be det	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Cord: w require been signature should b	Small Cell lung Caranoma 12 Yes 2 No 3 Probably 4 Unknown
Il Records, The law requires t cate has been signe page 2 should be	Commany artony arease  24a. Was an autopsy prior to completion of cause of death?
al Ricate It page	Atrial thrilation 10 Yes 200 No
Vital Recsician: The law	25. Was case referred to medi examiner?  1  Yes 2 No  1 No Page 1 No Service   1 No Page 2 No Se
g Physi er this o eral dir	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
ion ath. or: Aftu	2 Accident investigation M 1 Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requires t is after death.  si Director: After this certificate has been signe ed in by the funeral director, page 2 should be Certification; To Be Completed by	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Dital of urs aff urs aff illed ii	Continue 17 Continue Physician Theorem
ne Hospi n 24 hou he Funei bletely fili edical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Division of Vital  To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,  Medical Certification; To Be C	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	Circly Huang MD PAS-19027 April 20, 2004
lot	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	31. Date filed (Month, Day, Year) Day Registrar's Signature
State Registrar	31. Date filed (Month, Day, Year)  APR 2 3 2004

			1 - For State Registrar	State of Maryland		artment of H			giene Reg. No	2001.	12646
	Physici		Decedent's Name (First, Middle, Last)			San	Der	2. Date of De Month PRIL	Da	Year 1004	3. Time of Death
	/Medic Examin Funeral Director		4e. Fecility Name (If not institution, give s Light Hopkins Ho 5. Social Security Number 6. Sex	SPITAL	st birthday) Yrs.	4b. City, Town, or BALT IT	Location of Death  CORE  If Under 24 Hrs.  Hours Min.		th	N/A 9. Birth	place (Stelle or Foreign
	D .	Director	216-07-8423	10c. City,	Town or Lo			тверс.			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
9036	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-1 show is Medical Examiner must be notified at	Completed by Funeral Dire	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 [] Yes 2 [] No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba  1 Yes 25 No	Specify:	pecify Yes or No o Rican, etc.)	)-		can Indian, etc.
21215-0036	d within 72 h giene. er than "nate the Wedice.	complete	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		16a. Dece (Give life.	dent's Usual Occupi kind of work done of DO NOT use retired Salesman	during most of wor f)	rking		attery C	·
Maryland	S should be filed and Mental Hygid is marked other sumatic event, II	To Be	17. Father's Name (First, Middle, Last) Herman 19a. Informant's Name/Relationship (Ty)	Sand		ng Address (Street	18. Mother's Nam  Marie  and Number or Ru	s S	eife	ert	o Code)
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinet must be notified at Once.		Roger J. Sander ()  20a. Method of Disposition  1 A Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	Son)  emoval from State   20b. Pla	7824 ace of Dispo metery, cre raine	Linthicustion (Name of matory or other place Park Cent 2. Name and Address CCully-Po	IIII Road F	asadena Date	Ma 20c. Lo Ba	ryland 2 ocation - City or To	1122 own, State Maryland
	Physician /Medical		23a. Part 1. Exert the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. e cause on each line.  Due to (or as a conseque	Do not en		g, such as cardiad			Maryland	Approximate Interval Between Onset and Death
68760,	cate be executed physician and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter propertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque							
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 manths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □Live birth 2 □ Fetel of 4 □ Pregnant at time of dea 9 □ Unknown	death 3[	☐Ectopic pregnancy ☐ Other (specify)				23d. Date ol delive Month	ery Day Year
<u>α</u>	w requires that been signed b should be deta	ted by PI	Part II. Other significant conditions con		ting in the c	inderlying cause give	en in Part I.	23e. Did to			ne cause of death?
al Records,		Completed by								prior to con death?	psy findings available mpletion of cause of
Vital	Physician: rthis certifica ral director, i	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 Inpatient 2□E	R/Outpatie	nt 3 DOA Othe	26. Place of Dea			6 ⊡Other (Specifi	
Division of	e fe	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time o Injury	f 28c. Injury Work	the first commence with a	28d. Describe h			77
Divi	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu		3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)				City or Tov	wn, State		
	the Hose in 24 ho the Fund pletely f	edical	29a. Certifier 1 ☑ Certifying Phys (Check only one) 2 ☐ Medical Exemir	ician: To the best of my know ler: On the basis of examination and manner stated.	on and/or in	vestigation, in my of	oinion, death occu	rred at the time,	date and	) and manner as st d place, and due to	the cause(s)
	To T To 1	Σ	29b. Signature and title ol certifier	To the	1	29c. License				te signed (Month,	
	10		30. Name and address of person who co	TScinius Mesics mpleted cause of death (Item:		Print)	-000			eil les é	
	Sta Regist		31. Date filled (1971/15 P.3. 731) 4	432. Registrar's Signatu		Coaks.	Joseph Ste	HT BUIL	AT ALM	L D benefici	19616

			Please	-			e ink. Ensure /	-	_	
			For State	State of	maryland / l	•	nt of Health and	Mental Hygi	0.0 -	1 10-1-
	-		Registrar  1. Decedent's Name (First, Middle, Las	el .		Certifica	te of Death	2. Date of Death	g. No. 200	4 26 7
	Physici	an		-	0 0 .	- h		Month	Day St. Yeer	3. Time of Death
	/Medic		IRMA M.		ambau		, Town, or Location of Dea	April	01-000	+ 10:50PM
	Examir	ier	4a. Facility Name (If not institution, give	2 1			s- 1 1		4c. County of Dea	
	Function		Franklin Square 5. Social Security Number 6. Se	HOSP	Age (In yrs. last bit		ROCCOLOR or 1 Year If Under 24 Hrs	8. Date of Birth	DUT IT	thplace (State or Foreign
	Funeral Director			□M 200 F	90	Yrs. Months			Year) Co	ountry)
	_		Usual Residence of Decedent					1000	1114 1110	y your ki
_	arylan show	_	10a. State 10b. County		10c. City, Tow	n or Location	11			10d. Inside City Limits
9	the Ma 28a-f	cto	MD BALTIN	nore	Ye	erry	Hall			1 ☐ Yes 2 No
5	.≘ 5 •	Dire	10e. Street and Number	Λ	0.	10f, Z	ip Code	10	g. Citizen of What Co	ountry?
Ē	€ 23 €	Funeral Director	0022 Hilltop	HCRES	Kd.		21128.		USP	<del>-</del>
Ĭ		nue	11. Marital Status	Armed Force	ent Ever in U.S. es?	13. Was Dec If Yes, sp	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	erican Indian , te, etc.
36	s at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	PE 140	1 ☐ Yes	2 KNo Specity:		Specify:	hite
_ P	72 hour natural	ed	15. Decedent's Ed	ucation		. Decedent's Us	ual Occupation	1	6b. Kind of Business	Andustry
<u> </u>	E . c &	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4		(Give kind of w life. DO NOT	ork done during most of wo	rking	BALTIMO	RECITY
25	70 70 10 10	Com	12	Conbgo (1 4	D	ispat	ch	-	Public	Works.
OB	e filed al Hygi I other vent. L	Be (	17. Father's Name (First, Middle, Last)		_		18. Mother's Na	me (First, Middle, M	aiden Sumame)	
_O <u>e</u>	should be filed and Mental Hygi s marked other umatic event.	2	UNKNOWN				UNKAY	DWN		
Stamba	s 1 and 2 should be filed f Health and Mental Hyg itam 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship (7	ype, Print)	19b	. Mailing Addres	s (Street and Number or Ri	ural Route Number,	City or Town, State,	Zip Code)
کے ہے	1 and 2 Health Ism 27 i		Kevin Shillenn	grand		022 F	filtop Acre	5 Rd. le	rry Hall	MD 21128
100	0 = =		20a. Method of Disposition  1 A Burial 2 Cremation 3	Removal from St.	camata	f Disposition (Na ry, crematory of	me of other place)	Date 2	0c. Lation - City or	Town, State
S) =	nit. Pages vartment of ortant: If it injury or o		* 4 □Donation 5 □ Other (Specify			lawale	metery 4-	24-04	Paltimo	re MD
Balt	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Ligens	100		22. Name a	nd Address of acility	BALTIMO	RE, MD	21234.
	00 E 4 0		Kinberly 4.	Jupol		EVAN:	SFUNERAL	CHAPEL	, 8800 HAR	FURDRO
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	fications that cau	sed the death. Do	not enter the mo	de of dying, such as cardia	c or respiratory arres	it,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a MI						Oriset and Death
	/Medical Examiner		resulting in dealin)	Due to (or	as a consequence	of):				
		_	Sequentially list conditions,	b. CHD	as a consequence	of):				
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	00 01 600	as a consequence	oi).				
	xecu al-trai	xar	that initiated events resulting in death) Last	c Due to (or	as a consequence	of):				
760,	te be executed ysician and te burial-transit									
687	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Medical		d						
Вох	nding use a	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco					23d. Date of del	livery
	death a atte d tor	Cla	in the past 12 months? 1 □ Yes 2 ☑ No	4□Pregnan	n 2 ☐ Fetal death it at time of death	3 □Ectopic p 5 □ Other (s			Month	Day Year
0.	that the di ed by the detached	hys	9 Unknown	9□ Unknow	n					-
ώ.	signed I	y P	Part II. Other significant conditions co	ntributing to deat	h but not resulting in	the underlying	cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
p	v require been sig should b	edi	Chlon' < Kei	nal I	ns uff.	<1-er	4	1 ☐ Yes	2 2 No 3 □ Pr	obably 4 Unknown
် လ	e law re has bei je 2 sho	plet	Demention					24a. Was an	24b. Were au	itopsy findings available
a.	The laste has page	mo.						autopsy performe 1 ☐ Yes 26	ed? death?	completion of cause of 2 □ No
ta	ysician: Th is certilicate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Dea	ath Check onl one		2010
<b>5</b>	di is	To	1 Yes 2 No		atient 2 ER/Ou	tpatient 3 0	OA Other: 4 Nursing H	lome 5 ☐ Residen	ce 6 □Other (Spec	cify)
0	ding Ph h. After th tuneral	:uo	27. Manner of Death 1 Z Natural 5 □ Pending	28a. Date of I (Month,	Injury 28b. 1 Day Year) I	Time of njury	28c. Injury at Work?	28d. Describe how	injury occurred	
Sio	Attending r death. ector: After by the fune	catl	2 ☐ Accident investigation			М	1 ☐ Yes 2 ☐ No			
∠ Division of Vital Records,	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	289. Place of	Injury - At home, fa , etc. (Specify)	rm, street, facto	y, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	urs al		200 000000	<u> </u>						
	Hos 24 ho Fun Fun	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	iner: On the basi and manner	s of examination an	o, death occurred d/or investigatio	l at the time, date and place n, in my opinion, death occu	red at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Mec	29b. Signature and title of certifier	and manner	sialou.	29	c. License number	290	d. Date signed (Month	h, Day, Year)
	F 3 F 8		mo Olio	.0 ~ '			D56979		11-	
	18		30. Name and address of person who c	ompleted cause	of death (item 23a)			1	190-10r	
			Dr.Chardon, Mag	tai an	m Frank	slin 9	quare Driv	e Baltin	more Mi	ח בוב ר
	Sta	_	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signatur	Anne	6		1	- VI WO 1
	Registr	ar	APR 2 3 2004		~	-				

MARY SIMPSON

				ype or Print in				•		
			State	State of Marylar		artment of Heal rtificate of Dea		_	2001	1261.0
			Registrar  1. Decedent's Name (First, Middle, Last)			Timeate of Det		2. Date of Death	1	3. Time of Death
	Physicia		DOROT	ΉΥ J.	S	HERR		APRIL 1	19 <sup>Day</sup> 2004 <sup>Year</sup>	11:00 PM
	/Medic Examin		4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town, or Loca	ation of Death		4c. County of Death	
			JEWISH CONVALESCE	NT CENTER		BALTIMOR			BALTIM	
	Funeral		5. Social Security Number 6. Sex	M 2 F 7. Age (In yrs.	last birthday) 84 Yrs.		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, FEB. 7, 1	Year) 9. Birthn	place (State or Foreign htry)
	Director		220-07-9529 Usual Residence of Decedent	^	04			FED./,1	.920	טויו
	yland		10a. State 10b. County	10c. C	ty, Town or L	ocation			1	0d. Inside City Limits
	Ba-1 s	Director	MD BALTI	MORE	RAN	DALLSTOWN				1 □ Yes 2 No
	with the	Dire	10e. Sfreet and Number	D		10f. Zip Code	01100	10	g. Cifizen of What Coul	-
	eath v	Funeral	4048 CARTHAGE ROA	2. Was Decedent Ever in U	J.S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Mo	21133 nic Origin? (Spe	cify Yes or No-	14. Race - Americ	U.S.A.
0	after d or iten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1			tican, etc.)	Black, White,	
3	ours a	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No Sp	pecify:		Specify:	WHITE
5	filed within 72 hours after death with the Maryland Hydione. ther than "naturel", or items 23e or 28e-f show int, the Madical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of workin	g 1	6b. Kind of Business/In	dusfry
7	withir ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		AL OFFICE A	DMINIST	RATION	LOTHING MAI	NUFACTURING
	filed If Hygi other	Be C	17. Father's Name (First, Middle, Last)		1 4 1 1 1 1 1				faiden Sumame)	
<u>a</u>	should be filed with nd Mental Hygiene marked other tha umatic event, the	To E	SAMUEL		SPEES	LER !	BESSIE			SINGER
	and and is my	7	19a. Informant's Name/Relationship (Typ	. ,		ng Address (Street and A				
ב ב	1 and Health tam 27 other tr	- 24	JANET SIMPSON / D  20a. Method of Disposition	AUGHTER 20b.		48 CARTHAGE osition (Name of	D		STOWN, MD 2 20c. Location - City or To	
2	ages int of it t: if its		1 🛱 Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	annoval moin State			PARK 1	/2004		
pairimo	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License			LOM MEMORIA  2. Name and Address of			REISTERST SON & BROS.	
Ď	Depa impo any is		Jay (May)	pi		8900 REISTE	301			
			23a. Par ). Ent / the disease, or co / pli shock, or leart failure. List why	ations that caused fhe dea e cause on each line.						Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition	DIZLE	e me	or Disc	000			Onset and Death
	/Medical Examiner		resulfing in death)	ue to (or as a conse	quence of):	-1 - 1	ļ.			
	X	35	Sequentially list conditions, if any, leading to immediate	Due to for as a consa	The contract of the contract o	-1400		-		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
ב ב	executed an and rial-transit		resulting in death) Last	Due to (or as a conse	quence of):					
-	eath certificate be executed attending physician and for use as the burial-transit	cal	d							
X OX	certificate Iding phys	/Med	IF FEMALE:	3c. If yes, outcome of pregn	angu					
X Q Q	that the death cer ed by the attendir detached for use	clany	in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of	al death 3 l	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	Day Year
j.	Q 0 Q	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
ري ح	law requires that the as been signed by th 2 should be detache	by Physician/Medi	Part II. Other significant conditions con	_ \	sulting in the t	underlying cause given in	Part I.	23e. Did tob	acco use contribute to the	
ecoras,	equire en sig ould b		to the Con	e Martin	tus			1 🗆 Ye	s 2 No 3 Prot	pably 4 Winknown
ပ္	law ras be	Completed						24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
	: The cate h	Con						perform 1 Yes 2	death? No 1 ☐ Yes	2 No
VItal	Physician: The law this certificate has braid director, page 2 s	Be c	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	750/Outonia	Other		(Check only one		
0	Phy this ral d	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐	28b. Time o	-			nce 6 Other (Specif w injury occurred	y)
0	Attending I r death. ector: After by the funer	atio	1 Accident 5 Pending investigation	(Month, Day Year)	Injury	M 1 ☐ Yes	2 🗆 No			
DIVISION	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec		reet, factory, office	2	8f. Location (Str. City or Town,	reet and Number or Rura , State)	Il Route Number,
	urs aff			1-1 <del>-</del>						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical		ician: To the best of my kn er: On the basis of examin and manner stated.						
	o the	Me	29b. Signature and title of certifier			29c. License nun	mber	29	d. Date signed (Month,	Day, Year)
	->-0		> neue RL	Comer		MC-C.	753		4/19/64	0
	10		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type	Print)	, 12- 5	1 2 2	20	
	Ø		4000 Cld Ca	A 1200	× 1/	10 miles	7111	1.917	100	
	Sta Regist		31. Date filed (Month, Pay Year) APR 23 2004	32. Registrar's Sign	Ly	Sparled				
					-	The state of the s				

ORIGINAL

				State of Maryla					•	
			1 - State Registrar			rtificate of			eg. No 2004	12650
	Physici	ian	1. Decedent's Name (First, Middle, Last) HILDA			SCHAPIRO		2. Date of Death	Day Year	
	/Medio		4a. Facility Name (If not institution, give s	treet and number)			or Location of Deatl	Hovil	20 2000 4c. County of Dea	
			LEVINDALE HEBREW H			BALTIMO				N/A
	Funeral Director			M OF IT	s. last birthday) 94 Yrs.	If Under 1 Year Months Days		8. Date of Birth Month, Day, FEB. 3,1	.910 9. Bi	rthplace (State or Foreign ountry)
land	MO MI		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
death with the Maryland	r 28a-f show	ctor	MD N/	Α	BALTI	MORE				1 X Yes 2 □ No
with th	be no	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What C	•
death	ns 23.	Funerai	2434 W. BELVEDERE	2. Was Decedent Ever in	U.S. 13. V	Was Decedent of I	21215 Hispanic Origin? (S	pecify Yes or No-	14. Race - Am	
5-UU36 72 hours after o	ral', or Itams 23a or Examiner must be	b	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	f Yes, specify Cub 1 ☐ Yes 2 💢 No	Hispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Black, Whi	
2 0	"natural', dical Ext	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup	during most of wor	rking	16b. Kind of Business	:/Industry
within	than	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEM	00 NOT use retire IAKER	d)		OWN HOME	
	a Hyg	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	faiden Sumame)	
rylan	narked natic	To	MEYER  19a. Informant's Name/Relationship (Type	2004	LEVIN		LENA			FRIEDMAN
, Ma and 2 s	r neally and Mer item 27 is marke othar traumatic		MARVIN S. SCHAPIR	*					City or Town, State, ARTSTOWN,	/
י - יש	If item or otha		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b.		sition (Name of natory or other pla		_	20c. Location - City or	
aitimor	=		'4 □ Donation 5 □ Other (Specify)	0H	IEB SHAL	OM MEMOR	IAL 4/2		REISTERS'	
<b>A</b>	Department Important any injury Once.		21. Signature of Funeral Service License	θ					N & BROS. KESVILLE,	
	15		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the dea						Approximate Interval Between
	ysician	7.4	Immediate Cause (Fina) disease or condition	acute	myo	Osdie	e into	rub'a	1	Onset and Death
	ledical aminer		resulting in death)	Due to (or as a conse	equence :	1.	1.10			- / //
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):	ary.	an gu	se_		7 small
ou, be executed	and I-transi	Examiner	rany, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	orugnos of):					
7 <b>00</b> ,	been signed by the attending physician and should be detached for use as the burial-transit	caiE	d		querice or).					
tifica	ing phy e as th	g	IF FEMALE:	177						
Bath cer	attend for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	Sc. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of	tal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of del Month	livery Day Year
j et	oy the ached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	death 5	Ciriei (specily) _				
es tha	igned be det	by	Part II. Other significant conditions conf	ributing to death but not re	sulting in the ur	derlying cause giv	en in Part I.		acco use contribute to	
v requires	been s	eted						-	s 2 □ No 3 □ Pr	
The law requires that the death	2 5	Completed						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
	ertifica ictor, p	BeC	25. Was case referred to medical examiner?				26. Place of Dear	1 ☐ Yes 2 l th Check onl one	/	2 □ No
Physic	After this certificate ha funeral director, page	2	1 Yes 2 No		ER/Outpatient				nce 6 □Other (Spe	cify)
SION	: After	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1 □	yay k? Yes 2□No	28d. Describe how	v injury occurred	
al or Atta	I Director:	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre ify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
To the Hospital or Attanding Physician:	To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	ician: To the best of my kner: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred at the tir estigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manner as le and place, and due	stated. to the cause(s)
To th	To the	Ň	29b. Signature and title of certifier			29c. Licens			d. Date signed (Monti	
			Mejami	m)		האת	21.7	R	100 100K	2004.
	1		30. Name and address(of person who con	npleted cause of death (Ite	m 23a) (Type, F	lude	e au	e Bul	hore	2004. Red 2125
Н	Sta Registr		31. Date filed (Month, Day, Year) APR 2 3 2904	32. Registrar's Sign						

Schapiro, Hilda

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nd 2121	
Maryla	
Baltimore,	

			1 - For State Registrar	State of Maryland		artment of rtificate of		Mental H	ygiene Reg. No.(	2004	12651
	Physic /Medi		1. Decedent's Name (First, Middle, Las VENETT C. STON					A PRI	Day	Year 200	3. Time of Death 4 0730 A M
	Exami		4a. Fecility Name (If not institution, give SINAI HOSPITAI	,		BAI	or Location of Deal	h	7	County of Dea	th
	Funeral Director		5. Social Security Number 6. Security Number 11 213-30-2794 Usual Residence of Decedent	7. Age (In yrs. In 2√2) F	ast birthday) Yrs.	If Under 1 Yea Months Day					thplace (State or Foreign buntry) RYLAND
	Maryland	tor	10a. State 10b. County MD • N/A		, Town or Lo						10d. Inside City Limits 1 → Yes 2 → No
	with the 3a or 28a	Funeral Director	10e. Street and Number 1901 N. MONROE	ST.		10f. Zip Code 212				en of What Co	ountry?
980	n 72 hours after death with the Maryland "natural", or lieme 23a or 28a-f show polical Expranter rival by notified at	þ	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give <sup>A</sup> Year or Dates:	ı	Was Decedent of Yes, specify Cu	Hispanic Origin? (Suban, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)		4. Race - Ame Black, Whit	
21215-0036	e * (3)	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) -10-		(Give life. L	tent's Usual Occ kind of work don DO NOT use retii SEKEEPIN	e during most of wo red)	rking		d of Business	
Maryland	should be filed within and Mental Hygiene.  s marked other than umatic event, the M	To Be (	17. Father's Name (First, Middle, Last) EMMITT CLARK				18. Mother's Na	me (First, Middle E CLARK	e, Maiden S	Sumame)	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then any injury or other traumatic event, ILEM ODGS.		19a. Informant's Name/Relationship (7  THOMAS STONE (S  20a. Method of Disposition  1 □ Burial 2 ဩComation 3 □  4 □ Donation 7 □ Other (Specify	ON)  20b. Pi ce Removal from State MEMO	1901	N. MONR			MAR 20c. Loc	YLAND eation - City or	21217
Baltir	permit. P Departme Importen any injury 2009.		21. Signal and Frail Service Line	'	IIBNER	Name and Add	ress of Facility PI	ILLIPS	FUNER	AL HOM	
8760,	Physician /Medical Examiner upon the private and the private a	icai Examiner	23a. Parf /Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.	ACTE		ying, such as cardia		arrest,		Approximate Interval Between Onset and Death YEALS
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	Ectopic pregnan	су		23	3d. Date of del Month	very Day Year
	luires that n signed b uld be deta	d by Pl	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the ur	nderlying cause g	jiven in Part I.		tobacco us		the cause of death?
of Vital Records,	: The law requir cate has been s page 2 should	Completed by	WEIGHT	L055				24a. Wa: auto perf 1 \( \text{Yes}		24b. Were au prior to death?	topsy findings available completion of cause of
ion of Vita	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ation: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju		ath (Check only dome 5 Res 28d. Describe	idence 6		sify)
Division	oepital or Attendous after deatl hours after deatl unerel Director: ly filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,		eet, factory, office			(Street and own, State)	Number or Ru	ral Route Number,
	To the Hoepital or within 24 hours after To the Funeral Dir. completely filled in I	ledicai	(Check only 2 Medical Exam	rsician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	estigation, in my	opinion, death occu	, and due to the irred at the time	, date and p	lace, and due	to the cause(s)
	With To	M	29b. Signature and title of certifier  WHELESSEE	M-D.		_	0 584 5	7	APRIL	signed (Month	
	1		30. Name and address of person who come NAMA CEASAR )	821 N. EUTA	IW ST		, BALTI	MORE	M	0 219	201
	Sta Registi		APR 2 3 2004	32. Registrar's Signar	gre pape	rockel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year <sup>e</sup>Physician 10-55 AM beth APRI 20 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARE BALTIMORE AUNES HEALTH 7. Age (In yrs. last birthday) 8H Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 214-16-9305 Months Days Hours Min. 1 □ M 2**X** F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other then "neturel", or liems 23s or 28e-f show treumetic event, the Madical Examination and be notified at Maryland 1 Yes 2 □ No Completed by Funeral Director imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nester 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race -American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) perator d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ooper ۵ nar Son Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health Md 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R
14 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State permit. Page Department of Importent: If any injury or once. Calvary Cem 22. Name and Address of Facility

JOSEPH L. Rus 21. Signature of Funeral Service Mensee Homad 21216 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failule. List only one cause on each line. W. North Ave Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician HEART CONCLESTIVE YEARS /Medical Due to (or as a consequence of): **Examiner** VERKS HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate ha irector, page 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 ☑Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death | Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Manmeet Kause Resident P17597

Registrar DHMH 17 Rev 1/2001 900.

🗸 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KMUR

MANMEGT

APR 2 3 2004

31. Date filed (Month, Day, Year)

APRIL, 20, 2004

			For State Registrar		State	of Maryla		artmen <i>rtificat</i>				lental Hy	giene Reg. No.	200	14	12653
			Decedent's Name	e (First, Middle,	Last)				-			2. Date of De	aath			3. Time of Death
	Physic /Medi		Betty G.	Troig	a h							Month April	Day 2 1	200	Year ∕ı	11:40 A M
	Examir		4a. Facility Name (I			numbe:)		4b. City,	Town, or	Location of	of Death	White	4c.	County o	*-	11140 A
			Holy Cro	oss				Bur	tons	ville	2		_ N	/onto	iome.	ry Co.
	Funeral		5. Social Security N	umber (	5. Sex ¥ 1 ☐ M 2 ☐ 1	_	rs. last birthday)			If Under		8. Date of Bi	rth	TOTAL CO	9. Birthp	lece (State or Foreign
	Director		301-16-03	309	1 L M 2 LT	<u> </u>	86 Yrs.	I I I I I I I I I I I I I I I I I I I	Days	110013	10000	JUNE 2		917		nsylvania
	pu x		Usual Residence of 10a, State	Decedent 10b, County		10c	City, Town or Lo	ncation			-				1	10d. Inside City Limits
	sho	ō	MD	,	Arunde]										'	1 ☐ Yes 2 ☐ No
	28a-f	Director	10e. Street and Nun		AL WIGE	.   06	essup	10f. Zip	Codo			1	10a Citi	zen of Wh	ot Cour	
	a or	급			v.ā				2079	4				2011 01 441	iai Cobi	ntry r
	eeth	Funeral	2927 Jes	sup roc	T	ecedent Ever in	US 13				inin? (Spe	ecify Yes or No	USA	14 Bace	- Americ	can Indian.
10	lter d	Fu	1 Never Marri	ed 2∏ Marnie	Armed	Forces?	. 4.6.	If Yes, spec	city Cuba	n, Mexicar	, Puerto	Rican, etc.)			White,	
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21215-0036	within 72 hours after deeth with the Maryland ene. than "neturel", or Items 23e or 28e-f show he Madical Examinet must be notified at	Completed	/0	15. Decedent's		1	16a. Dece				A - 6 d		16b. Kir	nd of Bus	ness/In	dustry
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p	be filed within 72 hours after deeth with the Marylan ital Hygiene. Id other than "natural; or Itema 23a or 28a-1 show a other than "natural; or Italiad at swent, the Madreal Examinat must be notified at	Be (	17. Father's Name	(First, Middle, L.	ast)					18. Mothe	er's Name	(First, Middle				
<u>la</u>	should b ind Menti marked umatics	10	John Ho	y Graml	.ey					Rose	e Bar	bara Z	iegle	er		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumalic svent, the M		19a. Informant's Na	ame/Relationshi	p (Type, Print)		19b. Mailir	ng Address	(Street a	ind Numbe	or Rura	i Route Numb	er, City or	Town, S	ate, Zip	Code)
	and alith n 27 er tr		Barbara	Heckend	lorf - d	laughter	2927	Jess	up R	oad,	Jess	up, MD	207	94		
Baltimore,	jes 1 and 2 should t of Health and Men if Itsm 27 is marke or other traumatic		20a. Method of Disp	oosition	3 Demoval fr		<ul> <li>Place of Dispo cemetery, crer</li> </ul>	sition (Nar natory or o	ne of ther place	9)	C	ate	20c. Lo	cation - C	ity or To	wn, State
Ĕ	Pag nent ant: I		' 4 □ Donation				altimore	Wash	ı. Cr	m.	4/27	/2004	Lá	aure]	, M	D
alt	Department of He Important: If its any injury or oth once.	J.	21. Signature of FA	A W 11				. Name an			•	2				
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			23a. Pert1, Enter It shock, or hea	ne disease, or c nt failuie. List o	omplications th	at caused the de	eath. Do not ent	er the mod	le of dying	, such as	cardiac c	r respiratory a	rrest,	- / 1·11		Approximate Interval Between
28	Physician		Immediate Cause ( disease or condition	rillai		umonia									ş	Onset and Death  1 · Week
4	/Medical		resulting in death)	- 4	d	to (or as a cons	equence of):									I week
6	Examiner		Coguestially list on	aditions	b. Dem	entia									7	5 years
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	nd	Examiner	that initiated events		с.											
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9 )	ing pl	Med	IF FEMALE:		2		111111111111111111111111111111111111111							-		
Вох	leath certific attending p	an/	23b. Was decedent in the past 12			outcome of preg re birth 2 ☐ Fe		Ectopic pr	egnancy				2	3d. Date		Day Year
0.	tt the dec by the a tached for	slc	1 ☐ Yes 2 ☐ 9 ☐ Unknown			egnant at time o iknown	f death 5	Other (sp	ecify)			-		IVIOITI	'	Day Tea:
Ρ.	that the	Physician/Me	Part II. Other signif	icent condition	a contribution t	o doath but not r	equiting in the co	a da shiisa a		a ia Danil		22a Dida	abassa wa	-		ne cause of death?
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ecords,	w requ	etec											Yes 25	§140 3		aciy 4 donanown
ec	has the special person of the special person	Completed										24a. Was autor	osy	pric	or to con	psy findings available apletion of cause of
		Co										1 Yes	rmed? 200 No		ith? ] Yes	2 <b>X</b> No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case refer examiner?	red to medical	Hospital				0		of Death	(Check only o	nne)			
of	this ald the	٢	1 ☐ Yes 2 🔀 27. Manner of Death				ER/Outpatien			412190	-	ne 5 Resid			(Specify	")
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ā	1 th of	artif	4 Homicide	determin	ed 200. Fi	ace of Injury - At ilding, etc. (Spe	cify)	eet, ractory	, опісе		4	City or Tox		Number	or Hura	l Route Number,
u	Hospital 24 hours a Funaral E		29a. Certifier	1K) Cartifuing	Physician: To	the best of my le	nowledge death	. annumad	at the tim	o deto en	d place o	and due to the				
	Hos 24 hc Fun Fun	Medicai		2 Medical E	xeminer: On th	the best of my k e basis of exami nanner stated.	nation and/or in	estigation,	at the tim , in my op	e, date and inion, deat	d place, a th occurre	ed at the time,	date and i	place, and	er as st d due to	the cause(s)
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	Registi		APR	2 3 200	- 6-	Here	PA	food	2							

		1 - For Stata Registrar	State of Maryl	and / Dep	artme		lealth and	=		9 0 0	004	12	654
Physic	ian	Decedent's Name (First, Middle, Last						2. Date of Month	_ Da	iy o	Year 0.0.4	3. Time	
/Med	ical	Doris 4a. Facility Name (If not institution, give	Thomas		4b. Ci	tv. Town. or	Location of D				004 of Death	4:50	/ A
Exam	ner	Good Samaritan Nu		L		Baltir					N/	Ά.	
Funera Directo		5. Social Security Number 6. Se 214-12-4357		yrs. last birthday)		der 1 Year	If Under 24 h	Hrs. 8. Date of (Month) July	Day, Year	920	9. Birthp Cour Mar	plece (State otry) Yland	or Foreign
and		Usual Residence of Decedent  10a. State 10b. County	100	: City, Town or L	ocation						1	0d. Inside	City Limits
Maryli f sho	ğ	Maryland N/A			Ва	ltimo)	r.e.					1 <b>X</b> ]Ye	s 2 No
h the or 28a	Directo	10e. Street and Number			10f.	Zip Code			10g. C	itizen of	What Cour	ntry?	
death with the Maryland ms 23s or 28a-f show		4414 Springwood					21206			u.s			
ē 2 1	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 双 Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:				ispanic Origin? in, Mexican, Pi Specify:	? (Specify Yes or uerto Rican, etc.	No-		ck, White,	ean Indian, etc. Ute	
within 72 hours affended in a natural; or the Maulcal Extern	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	1			ation during most of f)	working	16b. Kind of Business/Industry				
w bid w	Com	12th Grade		Tel	epho	ne Op	erator				icati	ons	
B E D	Be	17. Father's Name (First, Middle, Last)						Name (First, Mic					
Should nd Mer marks	ို	Thomas L. Kamp  19a, Informant's Name/Relationship (7		19b. Mail	ing Addre	ess (Street a		Margare r Aural Aouto Ni		Roa or Town		(Code)	
VIO		Mrs. Barbara Dres	•										
or Healt		20a. Method of Disposition	20	Ob. Place of Disponentery, cre				Date				wn, State	
Pages nent of ant: If it ury or o	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		ardens o	of F	aith (	Cem. 4/						and
Dallimore, permit. Pages 1 a Department of Hes important: If item any injury or othe		21. Signature of Funeral Service Licen-	900					chimune					
U &0.5 = 6	-	23a. Pert1. Enter the disease, or comp	-					Bactin		พบ	21236	Approxim	ate
Physiciar /Medica		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	val ud						4		Interval B Onset and	etween
fou, te be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Right Due to (or as a cor	nsequence of):	06	rebra	l art	ery th	round	909 (9			
DOX GO sath certifical attending phy for use as th	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ②■No 9 ☐ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic ⊒ Other	c pregnancy (specify)	,		-		ate of delive	ery Day	Year
cords, P.O.  requires that the de been signed by the should be detached	þ	Part II. Other significant conditions of	ontributing to death but no	t resulting in the t	underlyin	g cause give	en in Part I.		Did tobacco				
VITAL MECOTAS, sician: The law requires t certificate has been signe rector, page 2 should be	Completed							a	Vas an utopsy enformed? es 220		Were auto prior to co death? 1  Yes	psy finding mpletion of 2 No	s available cause of
r VICAL MC ysician: The I is certificate ha director, page	Be	25. Was case referred to medical examiner?						Death (Check or	nly one)				
or V shysic this co	2	1 ☐ Yes 2 🖼 No		2 ER/Outpatre		DOA Othe	4 Minne	ng Home 5 F				y)	
LIVISION OF VITAL  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification properties of the funeral director of the funeral director.	Certification:	27. Manner of Death  12. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М		y at k? Yes 2 □ No	28d. Descr				d Route Nu	ımber,
Spital or / ours after neral Direc		4 Homicide determined  29a. Certifier Certifying Ph	building, etc. (Si	<i>pecify)</i> / knowledge, dea	th occurr	ed at the tim	ne, date and p	lace, and due to	Town, Star	and m	anner as s	tated.	
e Hot 24 h e Fur	edical	(Check only 2 Medical Exemone)	iner: On the basis of exa and manner stated.	mination and/or in	nvestigat	ion, in my o	pinion, death o	occurred at the ti	me, date ar	d place,	and due to	the cause	o(s)
To th withir To th comp	Me	29b. Signature and title, if certifier	4 - 0 - 1	4		29c. License	- 2		4	_		Day, Year)	
		Magarene	coo m	/		100	3461	50	4	- 2	2-0	4	
	)	30. Name and ad ress of person who of Dr. Jeffrey Cool	, 9712 Belai	r Rd., 3		e 203,	, Balti	more, Mi	21:	236		ra vsili—	
∯ S Regis	tate	31. Date (ADPRING 09. 2004	32. Registrar's S	Signature	las	Kal							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** EGETABILE JAETANA APRIL 33 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson TILCHRIST ENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex **Funeral** 215-44 199 Months Days Hours Min. 1 □ M 28 F Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ?? is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner mast be notified at 4.22.04 MARYLAND Director BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7024 AVENUE 21231 HAMLET Funeral TALY 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE 2 3 Widowed 4 Divorced VEGETABILE GAETANA Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygient Important: If item 27 is marked other tha any injury or other traumatic event. Italy once. LOTHING SEAMSTRES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GIUSEPPE DAIDONE GRAZIA IMINO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VINCENZO VEGETABILE HUSBAND HAMLET 1024 PARKVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State PARKVILLE, □Donation 5 □ Other (Specify EMETERY APRIL 20,204 MARKWOOD ( 21. Sona VIP S Funera S rvice Licens 22. Name and Address of Facility EVANS CHAPPL OF MEMORIES RD. HARFORD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Immediate Cause (Final disease or condition resulting in death) Privsician troke-/Medical Due to (or as a consequence of): **Examiner**

The law requires that the death certificate be executed

P.O.

Records,

Vital

of

Division or Attending

after death in by the

filled within 24 hours a

To the Funeral C

completely filled i

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Completed by Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No been signed by the should be detached

Be

2

Medical Certification;

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death 9 Unknown

Due to (or as a consequence of)

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Day Year

Approximate Interval Between Onset and Death

weeks

12655

4:00 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Year

SALTIMORE

DICIL

2004

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. stroke Prosv

24a. Was an

1 Yes 2 No 3 Probably 4 Unknown

autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Tyes 2 No

26. Place of Death Check only one) Other: 4 Nursin

g Home	5 Residence	6 Other (Specify)	423	10
28d.	Describe how inj	ury occurred	.1	

28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

29c. License number 25205 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (19 23a) (Type, Print) G-BINC 670

In St. Balts, MI

State Registrar 31. Date filed (Month, Day, Year) APR 2 3 2004

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 🗍 Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature house

DHMH 17 Rev 1/2001

**ORIGINAL** 

1 Inpatient 2 ER/Outpatient 3 DOA

			1 - State Registrer		artment of Health a rtificate of Death	R	eg. No. 2004	12656
	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Last)  Price of the Control of	y Wys	4b. City, Town, or Location of	2. Date of Deal Mooth Wilding		3. Time of Death 5=43/1+M
	Funeral Director			Age (In yrs. last birthday, Yrs.				ace (State or Foreign ry) YLAND
	he Maryland	ector	MD . 10b. County N/A	10c. City, Town or L	LTIMORE	11-11-11		od. Inside City Limits Yes 2 ☐ No
36	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show office! Exercites froughter from	by Funeral Director	10e. Street and Number  4719 NAVARRO AVENUE  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Deceder Amped Force: 12. Yes 2 If Yes, Give	]No	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No-	14. Race - America Black, White, e	oFA.
d 21215-0036	c * W	e Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12TH  17. Father's Name (First, Middle, Last)	r 5+)	dent's Usual Occupation kind of work done during most DO NOT use retired)  LE INSTALLER 18. Mother	of working	16b. Kind of Business/Ind  CABLE COMP  Maiden Sumame)	,
, Maryland	od 2 stith ar 27 is r trau	To Be	UNKNOWN  19a. Informant's Name/Relationship (Type, Print)  VERA HELEN WYATT (WI	F) 19b. Maili		ICE SMITH	City or Town State Zing	Code)21078 E, MD.
Baltimore,	permit. Pages 1 ar Department of Hea Important: if item any injury or othe ance.		20a. Method of Disposition Burial 2 Cermation 3 Removal from Stat 4 Donation 5 Other (Specify)  21. Signature of Foreral Service Licens	e GARRTS O	osition (Name of 4/7/0.) Nator ORESITO VET  Name and Address of Facility EWIS T. GWYN	4 Date CEM. OV	VINGS MILL  HOME @ ! @ !	on, State S, MD.
8760,	The law requires that the death certificate be executed x3 by W will be as been signed by the attending physician and up point and up p	dical Examiner	23a. Pari1. Entitle disease, or complications that caus shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or a d.	is a consequence of):	ter the mode of dying, such as a Tim will ne	ardiac or respiratory arre	est.	Approximate Interval Between Onset and Death Office of the Control
P.O. Box 6	that the death certific led by the attending p detached for use as	Physician/Med		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year
	v requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I.		acco use contribute to the	
of Vital Records,	certifica rector, p	o Be Completed	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 1 Thpar	tient 2 □ EP/Outpatier	Out	of Death Check on one	prior to com death? No 1 Yes 2	sy findings available pletion of cause of
Division of	After After fune	Certification: T	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Coulemined 28e. Place of In		f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred eet and Number or Rural	Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  1 Sertifying Physicien: To the besis and manner sand mann	of examination and/or in	h occurred at the time, date and vestigation, in my opinion, death	place, and due to the car occurred at the time, da	use(s) and manner as state te and place, and due to t	red. he cause(s)
	within To the Comp	≥	29b. Signature and title of certifier  The Declary Minimum and address of person who completed cause of The Min China	D-	29c. License number	29	d. Date signed (Month, Di Nameth 30,	ay, Year)
	3-1		30. Name and address of person who completed cause of Tour Min Carry 31. Date filled (Month, Day, Year) 32. Regis	death (Item 23a) (Type,	weth Hanner	St- Fait	inovezul.	21225
DH	Sta Registi MH 17 Rev 1/2	ar	APR 2 3 2004	- A A	W.			
				ORIGINA	\L			

			1 - For Registrar		epartment of Health and leartificate of Death	Mental Hygie	Z11114 12657
	Physic /Med	ical	1. Decedent's Name (First, Middle, Last)  L	Vimbish	4b. City, Town, or Location of Deat	1	Day Year 2.004 01:30 AM  4c. County of Death
	Exami Funera Director		Singi Hospi  5. Social Security Number 6. Sex	tal of Baltimon  7. Age (In yrs. last birtho  Yrs.	Baltimore C  (ay) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min	149 8. Date of Birth	9 Birthplace (State or Foreign Country)
	th the Maryland or 28a-f show e notified at	Director	Usual Residence of Decedent  10a, State  10b, County  10e, Street and Number	10c. City, Town o	r Location  1 th more  10f. Zip Code	10g.	10d. Inside City Limits  1 No 2 Yes 2 No Citizen of What Country?
Š	BAITIMORE, IMARYIANG ZIZID-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinat missible inclines at any injury or other traumatic event, the Modical Examinat missible inclines at mone.	by Funeral D	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1  Yes	21217 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Plack
E+1	Baltimore, Maryland Z1Z13-UU30 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel, or any injury or other traumatic event, the Medical Examt once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	ation 16a. Do	ecedent's Usual Occupation live kind of work done during most of work by DO NOT use retired)  OMESTIC WORK 18 Mather's Nor	king 16t  Cer P  ne (First, Middle, Mai	rivate Families
61.54,	Maryland 212 tid 2 should be filed with th and Mental Hygiene. 27 is marked other than traumatic event, tre.	To Be	Peter F. Co	) es 19b. Print) (SQn) 19b. M	lailing Address (Street and Number or Ri	iral Route Number, Co	rison
	Saltimore, IN bernit. Pages 1 and Department of Health Mportant: If Item 27 any injury or other tr ange.		20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. Signatore of Funeral Service License	emoval from State Arbut	sposition (Name of crematory of other place)  U.S. Mem.Park 4/5  22. Name and Address of Facility	Date 200 17/2004 A	S. Location - City or Town, State  Thutus, Md.
	NAME OF	Ĺ	23a. Porty. Enter the tylease, or complication, or hear the tyre. List only on Immediate Cause (Final	cations that the death. Do not e cause on each line.	Joseph Li Russ	or respiratory arrest,	Approxim te Interval Between Onset and Death
	Physician /Medica Examiner		disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Ericer Universitying Cause (Disease or injury	Due to (or as a consequence of)			2 days
9	8 / 6U, cate be executed shysician and the burial-transit	licai Examiner	Cause (Disease or injury that initiated events resulting in death) Last				
1	HECOTOS, P.O. BOX 68/60,  The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-translib.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 W No 9 ☐ Unknown	ac. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death  4 ☐ Pregnant at time of death  9 ☐ Unknown	3 Dectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
	HECOTOS, P. he law requires that: e has been signed b. tge 2 should be deta	by	Part II. Other significant conditions con  congestive h	tributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobaci 1 ☐ Yes	co use contribute to the cause of death?  2 XNo 3 Probably 4 Unknown
*	VITAI KEC. sician: The law certificate has b lirector, page 2 st	e Completed	25. Was case referred to medical		26. Place of Dea	24a. Was an autopsy performed 1 Yes 2 X	
	ing Phy After this	ation: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 X Inpatient 2 🗀 ER/Outpa 28a. Date of Injury (Month, Day Year) 28b. Tim Inju	e of 28c. Injury at	ome 5 Residence 28d. Describe how i	e 6 Other (Specify) injury occurred
i	DIVISION To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the 1	ai Certification:	3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Phys	28e. Place of Injury - At home, farm building, etc. (Specify) ician: To the best of my knowledge, d	eath occurred at the time, date and place	City or Town, S	e(s) and manner as stated.
	To the Hospital within 24 hours a To the Funeral I	Medical	(Check only 2   Medical Examinone)  29b. Signature and title of certifier	er: On the basis of examination and/o and manner stated.  M. D	r investigation, in my opinion, death occurrence of the second of the se	rred at the time, date	and place, and due to the cause(s)  Date signed (Month, Day, Year)  Oril 22, 2004
	Y\ S Regis	tate trar	30. Name and address of person who of SCOTT SEO, M.O. 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23a) (Ty			

DHMH 17 Rev 1/2001

ORIGINAL

Registrar

APR 2 3 2004

			For State Ragistrar	State of N	Maryland		artment rtificate			and Me		jiene eg. No20	UL	12659
	Physici	an	1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month	th Day	Year	3. Time of Death
	/Media	al	Yvonne Watt  4a. Facility Name (If not institution, g	ive street and numbe	r)		4h City	Town or I	Location of		pril	19 2 4c. County	004	11:23P M
1	Examir	er	Beechwood Assis						ville				1time	
	Funeral		5. Social Security Number 6.	Sex 7. /	Age (In yrs. la:		If Under Months		If Under 2	24 Hrs.	B. Date of Birth		9. Birth	place (State or Foreign ntry)
	Director		463-36-0671	1□M 2⊠F	77	Yrs.				1	(Month, Day March 1	9,1927	Mis	sissippi
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Mary a-f sh	tor	Maryland Baltim	ore		Wood	lawn							1 ☐ Yes 2 🛣 No
	or 28s	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cou	ntry?
	ath wi	ral	5 Seamus Court	1				207				U.S.A.		
36	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force: 1 Yes 2 2 If Yes, Give Year or Dates	s? ⊈No	] ]	Was Decedo fYes, sp <i>ec</i> 1 □ Yes 2	rty Cuban	, Mexican,	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		ck, White,	_
9-0	72 hours "natural", olest Exe	ted	15. Decedent's (Specify only highest of	Education		16a. Deced	dent's Usua kind of wor	l Occupat	tion	of working	,	16b. Kind of B	usiness/In	ndustry
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. L	DO NOT us	e retired)	a ang most	or working	<i>'</i>			
Maryland 21215-0036	12 should be filed within h and Mental Hygiene. 7 is marked other than " traumatic event, the Mas	Ö	17. Father's Name (First, Middle, La	L st)		Н	lomema		18. Mother	r's Name /	First, Middle, I	Own Maiden Sumar		
and	d be f ental l ked of	To Be	Thomas Clayton							cie R			,	
ary	shoul ind Me i mari umati	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address	(Street ar			Route Number	, City or Town,	State, Zip	c Code)
Ž	and 2 valth a n 27 is er tra		Gordon S. Watt	(Husband)		101 N	. Bee	chwo	od Av	venue	Catons	ville,	MD 2	21228
ore	of He of He if item or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	□Removal from Stat	e cen	ce of Dispo netery, cren	natory or ot	her place		Da	te	20c. Location	City or To	own, State
Baltimore,	Pag Iment tant: I		' 4 ☐ Donation 5 ☐ Other (Spec	cify)	St.	John					-2004	Ellicot	t Ci	ty, Marylan
Bai	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, it a Micdical Once.		21. Signature of Funeral Service Lic	2		16	30 Ed	Fun mond	eral son A	Home Ave.		ville,	le, ] Mary]	Land 21228
	Physician /Medical	.)	23a. Part / Enjer the disease, or co shock of heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each	line.	sunlar	7	or aying,		cardiac or	respiratory arr	əst, 		Approximate Interval Between Onset and Death
	be executed sician and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	is a conseque									
68760,	ate hy:	dical		d										
P.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown		2 Fetal d at time of dea	leath 3 🗆	Ectopic pre						te of delive	ery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death	but not result	ing in the ur	nderlying ca	use giver	in Part I.			acco use cont s 2 \( \sigma\) No	ribute to tl	he cause of death?
Division of Vital Records,	nysiclan: The law requ nis certificate has been I director, page 2 shoul	Completed									24a. Was an autops perform	y ned?	Were auto prior to co death? 1  Yes	psy findings available mpletion of cause of 2 No
Vita	iclan: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Other	. /		Check only on			
of	Phys r this ral dir	. To	1 Yes 2 No	1 🗆 Inpa		R/Outpatien 8b. Time of		A	4 Nur		d. Describe ho			y)
on	Attending Physiclan: r death. ector: After this certifics by the funeral director, I	ition	1 Natural 5 Pending 2 Accident investigat	28a. Date of In (Month, E	Say Year)	Injury	М	Bc. Injury a Work? 1 🔲 Ye	es 2□N			,,		
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Certification:	3 Suicide 6 Could not determine		njury - At hom etc. (Specify)	ie, farm, stre	eet, factory,	office		28	f. Location (Sti City or Town	reet and Numb , State)	er or Rura	I Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 ertifying I (Check only one) 2 Medicel Ex	Physicien: To the beseminer: On the basis and manner:	of examinatio	edge, death on and/or inv	occurred a restigation,	it the time in my opi	, date and nion, death	d place, an	d due to the ca at the time, da	use(s) and ma ate and place,	inner as st and due to	tated. the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier					License			25	d. Date signed	d (Month,	Day, Year)
	5		1 Taymond 11	We MD				) 4	768	3		4/20/04	4	
_	<u></u>		30. Name and address of person wh		death (Item 2		Print)	usks	nwef	WD				
A	Sta Registi		31. Date filed (Month, Day, Year)  APR 2 3 2004	Server 32. Regis	strar's Signatur	Apo	ds			_				

			1 - For State Registrar	State of Ma	aryland / I	Depa <i>Cer</i>	irtment of tificate of	Health a	and Me		jiene eg. No.		12660	)
	Physici /Medic		Decedent's Name (First, Middle, Last ROSCOE WYNN	st)						2. Date of Deat Month	Day	Year	3. Time of Death	
	Examir		4a. Facility Name (If not institution, given by SERS) TYSERS.  5. Social Security Number 6. S	ECIALTY H	OSPITA e (In yrs. last bii	L nhday)	4b. City, Town, BALTI If Under 1 Yea	MORE r If Under:	of Death	2/230	4c. (	County of Deat  N/A  9. Birt	h	_
	Director		223-10-8277 19	M 2□ F	91	Yrs.	Months Day	s Hours	Min.	(Month, Day,			IRGINIA	_
	yland how		10a. State 10b. County		10c. City, Tow	n or Lo	cation						10d. Inside City Limits	_
	Be-1s	Director	MD. N/A		BALT	IMO]							1 Tyes 2 □ No	_
	th with the	ai Dir	3009 DUPONT AVE				10f. Zip Code 2121	5		, 1	-	en of What Co JSA	untry?	
36	urs after dea si', or items maniner m	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Amed Forces? 1 Tes 2 H	No		Vas Decedent of Yes, specify Cu		gin? (Spec , Puerto R	cify Yes or No- lican, etc.)		4. Race - Ame Black, White Specify: B1		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examinat must be notified at ance.	Completed	15. Decedent's Ec (Specify only highest gra	ducation de completed) College (1-4or 5		(Give :	ent's Usual Occi kind of work don OO NOT use retii	upation e during most ed)	t of working	g		ARIS P	,	
Maryland 2	uld be filed Aental Hygi rked other tic event, u	To Be Co	17. Father's Name (First, Middle, Last) GEORGE WYNN							(First, Middle, M	Maiden S	Sumame)	JINI	_
Mary	12 sho h and h 7 Is ma reuma		19a. Informant's Name/Relationship (				g Address (Stree				•			
Baltimore, I	ages 1 and ent of Healt it: If item 2: ry or other i	3	BARBARA GROSS (N. 20a. Method of Disposition  1 Burial 2 Gramation 3 C 4 Donation 9 Other (Specific	Removal from State	20b. Place o cemete	f Dispos ry, crem	W. HENR sition (Name of natory or other pi EMATORY	ace)	ST. I	ate	20c. Loc	cation - City or	ND 21230 Fown, State MARYLAND	-
Balti	permit. Departm Importal eny inju		21. Signature of Fundal Service Licer		Brow	NE 32	Name and Add	ess of Facility MONR	y PHII OE SI	LIPS F	MER	AL HOME	E, P.A. YLAND 21217	
	Physician		23a. Pa 1 Enter the disease, or com stroot, or heart failure. List only Imme a Cause (Final disease or condition	one cause on each lir	the death. Do			ring, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	haont	dicar	0				1 - 1 - 0	
1	# H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U.	a consequence		/ Lesin -	C112 C 41					1048	-
8760, 🥎	be execut Sician and burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence	of):								_
687	rtificate ng physi as the l	Jedic	IE EEMIE.	. 0										-
P.O. Box	The law requires that the death certificate be execuate has been signed by the attending physician and page 2 should be detached for use as the burial-trans	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnan Other (specify)	су			23	3d. Date of deli Month	very Day Year	
rds, P	w requires that s been signed b should be deta	Ď	Part II. Other significant conditions of	hvillation	ut not resulting in	n the un	derlying cause g	iven in Part I.			accous s 2 🗓		the cause of death?	
	ilcien: The law re certificate has ber rector, page 2 sho	Completed	Loopinsey Jeilu	e ventilal	er dep	encla	1/-		<del></del>	24a. Was ar autopsy perform 1 Yes 2	y .	24b. Were aut prior to c death? 1 \(\sum Yes\)	opsy findings available ompletion of cause of	
Vita	sicien: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			_  c			Check only one	- /			
٥ د	ng Phys ter this neral di	n: To	1 ☐ Yes 2 ÎP No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 Dinpatie  28a. Date of Injur (Month, Day	y 28b. 1	itpatient Time of njury	3∐ DOA 28c. Inji	ry at ork?	sing Home 28	e 5 🗆 Reside 8d. Describe ho	nce 6 w injury	Other (Spec	ıfy)	-
ivision	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely illied in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At home, fa		M 1[	]Yes 2□N		3f. Location (Str. City or Town,		Number or Rui	ral Route Number,	
	To the Hospitel of within 24 hours at To the Funerel Completely filled in	edicai Ce	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medicel Exam	ysicien: To the best of	examination an	e, death	occurred at the	ime, date and opinion, deat	i place, an	nd due to the ca	use(s) a	and manner as	stated. to the cause(s)	_
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner sta	nea.			se number				signed (Month)	, Day, Year)	-
,	0		30. Name and address of person who				rint)	0494						
	Sta	ite.	31. Date filed (Month, Day, Year)	y specifit	ar's Signature				les si	- Balt	imare	emnx1.	130	_
	Registi		APR 2 3 2004	Lielan	a b		Sand							
DH	MH 17 Rev 1/2	001		-		1	3. sugar							

Rosacc wunn

		_	For State Registrar		aryland / Depa	artment of H rtificate of	lealth and Death		3	to UU
Ħ	Physici		1. Decedent's Name (First, Middle, La Roger Allen					2. Date of Dea March	26,2004	3. Time of Death 1:40p. M
	/Medic Examin	er	4a. Facility Name (If not institution, given 104 East Bal	timore St		Hager	r Location of Dea Stown,		4c. County of De Washi	ngton
	Funeral Director			Sex 7. Age 11∑M 2□F	(In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		7 <sup>Year)</sup> 949	irthplace (State or Foreign Country) MD
	Maryland	tor	10a. State 10b. County	.ngton	10c. City, Town or Lo Hagerst					10d. Inside City Limits 1 X Yes 2 ☐ No
	th with the 23a or 286 at be not	Funeral Director	10e. Street and Number 104C East Balt	imore St	•	10f. Zip Code 21	1740		U.S.A	
960	be filed within 72 hours after deeth with the Maryland Hygiene. Hygiene. did Hygiene. did other than "naturel; or ltems 23s or 28e-f show other than "naturel; or ltems 23s or 28e-f show event, the Medical Examinar must be notified at	<u>ا</u> م	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces?  1 XYes 2 1 1 Yes, Give Year or Dates:	1060	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🏋 No		Specify Yes or No- rto Rican, etc.)	14. Race - An Black, Wh Specify: W	
Maryland 21215-0036	filed within 72 h Hygiene. Ither than "natu int, the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th grade	a <i>de completed)</i> College (1-4or 5	+) 16a. Dece (Give life. B1	dent's Usual Occup kind of work done DO NOT use retire CICK Las	during most of wo			s/Industry /contractor
/land		To Be (	17. Father's Name (First, Middle, Last Chester Lynn		Sr.			Louise	Maiden Sumame) Rubeck	
	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship Joseph Albrig	(Type, Print) ht bro	ther 142	205 Nati	onal P	ike Clea		g, MD 21722
Baltimore,	Page nent o nnt: If ury or		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 [ 1 ☐ Donation 5 ☐ Other (Special Content of the Content		20b. Place of Dispo cemetery, crei Smithsk	esition (Name of matory or other pla ourg Cre	Mar.	2 <sup>7</sup> , 2004	20c. Location - City of Smiths	or Town, State burg, MD
Balt	permit. Departm Importe any inju		21. Signature of Funeral Service Lice	V- Funy	I	O.BOX	Edwin '	ear Spr	ing. MD	l Home, Inc 21722
	Physician /Medical Examiner	Examiner	23a. Par1. Enter the disease, or conshock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Due to (or as	10.			C or respiratory arr		Approximate Interval Between Onset and Death
× 68760,	death certificate be executed e attending physician and id for use as the burial-transit	ian/Medical Exan	that initiated events resulting in death) Last	c. Due to (or as d	a consequence of):					
P.O. Box	the death c y the attenc iched for us	Physician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)	<i>'</i>		23d. Date of d Month	elivery Day Year
	The law requires that the tee has been signed by th bage 2 should be detache	출	Part II. Other significent conditions	contributing to death be	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to		to the cause of death?  Probably 4Unknown
of Vital Records,		e Completed	25. Was case referred to medical				OG Place of De		med? prior to death?	autopsy findings available completion of cause of
N N	Physician: r this certific ral director.	To Be	examiner?	Hospital:	nt 2 ER/Outpatier	nt 3 DOA Ott	or	ath (Check only on Home 5 Areside	ence 6 ⊡Other (Sp	eecify)
o uo	nding Ph th. : After th e funeral		27. Manner of Death 1	28a. Date of Injur (Month, Da)	y Year) 28b. Time o	Wo	y at k? Yes 2 □ No	28d. Describe he	ow injury occurred	
Division	el or Attending P s efter death. I Director: After t d in by the funera	Certification:	3 Suicide 6 Could not t 4 Homicide determined		ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Si City or Town	treet and Number or I n, State)	Rural Route Number,
	To the Hospitel or within 24 hours effer To the Funerel Director Completely filled in D	edical (		hysicien: To the best of miner: On the basis of and manner sta	examination and/or in					
)	To the within	W	29b. Signature and title of certifier	) [ 26 III 14	7	29c. Licens	e number	4	9d. Date signed (Mon	200 4
r	H-37		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,	Print) 12,001	torchar	d tens	21742	,
	Sta Registi		31. Date filed (Month, Day, Year) NAR 29	100	ar's Signature	parte	, ,			

				partment of Health and Mental Hygertificate of Death	giene Reg. No. 2004 12662
	Physic		Decedent's Name (First, Middle, Last)     William Moroni Alvey	2. Oate of Dea Month March	th Day Year 3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			16813 Hampton Road	Williamsport	Washington
	Funeral Director		5. Social Security Number 529-16-9958  6. Sex 1XXM 2 F  7. Age (In yrs. last birthda) 81 Yrs.	Months Days Hours Min. 8. Date of Birth OCT 209,	9. Birthplace (State or Foreign
	yland IOW		10a. State 10b. County 10c. City, Town or I	ocation	10d. Inside City Limits
	a-1sh	ctor	Maryland Washington Wi	lliamsport	1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number	10f. Zip Code	Og. Citizen of What Country?
	eath v	erai	16813 Hampton Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	21795	USA
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23e or 28a-f show mary righty or other traumatic event, the Medical Examination that he multiple at angle.	Completed by Funeral Director	11. Marital Status	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes   Children  Childre	14. Race - American Indian, Black, White, etc.  Specify: White
2-Q	72 ho natur	eted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business/Industry
12	within ne. han "	mpje	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	
5 0	filed v Hygie Ither t	ပိ	12 17. Father's Name (First, Middle, Last)	Mail Supervisor  18. Mother's Name (First, Middle, M	United States Government
<u>a</u>	id be ental ked o	To Be	Lafayette P. Alvey	Sarah M. Shurt	
ary	shou and M s mar	-		ling Address (Street and Number or Rural Route Number,	
Σ.	and 2 ealth n 27 I		Norma Alvey - Wife 168	13 Hampton Road Williamsp	ort,Maryland 21795
ore	ges 1 t of H if iten		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State	ematory or other place)	20c. Location - City or Town, State
ij	it. Pa rtmen rtant: njury		'4 □ Donation 5 □ Other (Specify) Union Ce		Meyersdale,Pennsylvani
Ва	Depa Impo any i			ያንሪምክሮ ቸህክዮተ፭ባ <sup>iib</sup> Home,P.A. 25 S. Conococheague St. Wi	
	certificate be executed  EX  American and ding physician and use as the burial-transit	lical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	rcinoma Metastatic –	Opport and Death
ĕ.	death certific e attending p d for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
ο, σ	law requires that the as been signed by th 2 should be detache	by Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tob	acco use contribute to the cause of death?
ecords,	equir	ted	Hypertension Type II	Diabetes Mellitus 10 Yes	s 2 ☑No 3 ☐ Probably 4 ☐Unknown
ĕ	has be	Completed	Dementia	24a. Was an autopsy	
	n: The licate har, r, page		Normal Pressure Hydrocepho	perform 1□ Yes 2	
Vital	Physician: The lav this certificate has al director, page 2	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Check only one	
ō		P-	27. Manner of Death 28a. Date of Injury 28b. Time of	THE COLUMN THE SERVICES	
<u> </u>	kttending death. ctor: After y the funer	atio	2 Accident investigation	M 1 Yes 2 No	
Division	P 등 등 C	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
_	pite ours ierel	O	29a. Certifiler 1 Certifying Physicien: To the best of my knowledge, deal	h occurred at the time date and place and due to the co-	
	To the Hos within 24 h To the Fun completely	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the time, dar	te and place, and due to the cause(s)
		Ň	29b. Signature and title of certifier	29c. License number 29c	d. Date signed (Month, Day, Year)
6	81VA	-	Vonda Jof M	D38892	MARCH 23, 2004
	٦.		30 Name and address of person who completed cause of death (Item 23a) (Type,		Hagerstown,
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	11110 Medical Campus	4d. MD21742
	Registra	ar	MAR 2 4 2004 Marera 19. pg	seed	

			For	State of Maryla	ind / Dep	artment of	Health and	Mental Hy	giene	
			1 - State Registrar		Ce	rtificate of	Death	1	Reg. No. 200	4 1266
	Physici	an	1. Decedent's Name (First, Middle, Last,  Delia Morales A.					2. Date of De Month	ath 25, Day 2004 Yea	3. Time of Death
	/Medi					45 City Tarre	1		-	7:45 a м
	Examir	ner	4a. Facility Name (If not institution, give				or Location of Deat	٦	4c. County of De	
	Funeral	2	Washington Advent  5. Social Security Number 6. Sec		s. last birthday)	Takon If Under 1 Year	na Park		Montg	omery inhplace (State or Foreign
6	Director		219-64-6731	144 2075	O Yrs.	Months Days	Hours Min.	July 1		shington DC
	pu ,		Usual Residence of Decedent							
	anyla Shov	5	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	he M	ecto	Maryland Prince  10e. Street and Number	Georges	Hyat	tsville				1 XYes 2 No
	with t	ត់	3542 Dean Drive			10f. Zip Code 207	82		10g. Citizen of What (	Country?
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show fre Madical Evanting must be notified at	Funeral Director		12. Was Decedent Ever in	U.S. 13.			necity Yes or No.		nerican Indian,
(C)	ifter o	F	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 ☐ No			Hispanic Origin? (S pan, Mexican, Puert Dan			ite, etc.
က် တ	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		Yes 2□ No	Specify: Fue	rto Rica	Specify:	White
5-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dece	dent's Usual Occu	pation during most of wor	kina	16b. Kind of Busines	s/Industry
121	Mithin ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retire unts Rec		9	A = = = = = = = =	<b>:</b>
2	iled v tygie ther t		17. Father's Name (First, Middle, Last)		Acco	unts ked		- (F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Account	ng
and	od of	Be c	Isaac Alamo					Morales	Maiden Sumame)	
Maryland 21215-0036	should ad Me mark matic	ဠ	19a. Informant's Name/Relationship (Ty)	pe. Print)	19h Mailir	n Address /Stree	t and Number or Ru	ral Pouta Numba	r, City or Town, State,	Zin Code l
Σ	od 2 state at 27 is rtrau		Norma M. Alamo - S				ld Court;			ZIP Code)
ē,	s 1 a f Hea itam othe	1 /	20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	1	Date	20c. Location - City of	r Town, State
Ë	Page lent o nt: If ry or		1 ☐ Burial 2X Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State Fo		oln Crem	atory 3/	28/2004	Brentwoo	d, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is merked other than "natural", or items 23s or 28a-f show any injury or other traumatic evant, the Modical Examinet must be notified at ODCs.		21. Signature of Funeral Service License		22	. Name and Addre	ess of Facility Tox	t lines	ln Funeral	Home
m	88 = 8	2 2	MexinT. Role M	01322	3	401 Blad	ensburg R	d. Brent	th runeral	7722
8			23a. Part1. Enter the disease, or compli shock, or heart failure. List only on	cations that caused the de						Approximate Interval Between
) k =	Physician		Immediate Cause (Final disease or condition	Liver Cir						Onset and Death
Н	/Medical		resulting in death)	Due to (or as a conse	equence of):					
8	Examiner		Sequentially list conditions.							
	pe sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury	Due to (or as a conse	equence of):					
_	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	. Due to (or as a conse	aquence of):					
760	be e.	calE			14001100 01).					
687	ficate phys s the									
	nding use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of prega					23d. Date of de	Nines.
. Box	death e atte	iciai	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnanc Other (specify)	у		Month	Day Year
O.	at the de by the a stached	hys	9 Unknown	9□ Unknown						
	res tha igned b	oy P	Part II. Other significent conditions con	tributing to death but not re	sulting in the ur	derlying cause giv	ven in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
Records,	w require been sig should b							1 🗆 Y	es 2□No 3□P	robably 4 Unknown
ecc	law r as be 2 sh	Completed						24a. Was a		utopsy findings available
_		E O						autops perform	ned? prior to death? 2≦No 1 ☐ Yes	completion of cause of
Vital	ilcian: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Deat			20.10
	Phyalcian: this certific ral director.	P	1 ☐ Yes 2 ☑ No		ER/Outpatien		4   Nursing Ho	me 5 Reside	ance 6 □Other (Spe	ecify)
Division of	fter ne	Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe ho	w injury occurred	
<u>S</u>	or Attending ifter death. Diractor: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	00. 50			Yes 2 □ No			
$\leq$		artif	4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre ify)	et, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
_	id and		29a. Certifier 1 Certifying Phys	ician: To the best of my kn	nowledne death	occurred at the time	ne date and place	and due to the	augo/a) and m	a at a total of
	e Hos	Medical	(Check only 2 Medical Examin	er: On the basis of examin and manner stated.	ation and/or inv	estigation, in my o	pinion, death occur	red at the time, da	ate and place, and due	s stated. e to the cause(s)
	To the within 2. To the complete	Me	29b. Signature and title of centrier	00 -		29c. Licens	e number	2:	9d. Date signed (Mont	h, Day, Year)
	5		> /VL	TUSP.		D45	471		4/1/2004	
2	(2)		30. Name and address of person who							
			Dr. Yeheyis Negus	sie 1111	Spring	St. #214	, Silver	Spring M	laryland	
模	Sta Registr	_	31. Date filed (Month, Day, Year)  APR 0 6 2004	Registrar's Sign	ature Land					

State of Maryland / Department of Health and Mental Hygiene  $200l_{\downarrow}$ 12664 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 30 Pay 2004 **Physician** 8:30 Pm BETTY ANN ARNWINE /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES Pine View Nursing Home Clinton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 27, 1936 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Miss. 490-38-9222 67 Director Usuel Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f ehow edical Examiner must be notified at Pr. Geo. Bowie X Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nit. Pages 1 and 2 should be filed within 72 hours after death with to arment of Health and Mental Hygiene.
orbant: if Item 27 is marked other than "natural", or Items 23s or 2 injury 9, other traumatic event. If a Medical Examinat must be n. 8032 Quill Point Dr. 20720 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Montgomery Co. Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs Teacher Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Wills Buford Holloway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Arnwine (Daughter) 8032 Quill Point Dr., Bowie, MD 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial ②☐Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury og Mekro Funeral Ser. 4/5/04 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. f Funeral Service Liversee 21. Signature 246 N. Wash. St., Rockville, MD 20850 Approximate Interval Between Onset and Deuth 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No P.0. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred After Division To the Hospital or Attending 5 Pending investigation 1 Natural after death.
I Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) OLD LINE CONTER WALDONF, PAU.D - 12070 32. Registrar's Signature State 5 Registrar

/M	sician edical miner			(First, Middle, La Abate not institution, gin	Ambat			4b. City, To	wn, or Loc	cation of (	2. Date of Month April	1 ,	2004 County of Death	3. Time of Death 1:27p M
Fune			7620 M		Sex		. last birthday)	If Under 1		Under 24	Hrs. 8. Date of Min. Feb.	Birth	fontgomer	y place (Stete or Foreign ntry)
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the Maryia 28a-f shor	Director		MD Street and Num	Montgom	ery	100. 0	Takoma		ode			100 0	itizen of What Cou	XX Yes 2 □ No
3 with	Ö			ple Aven	ue #723				912				ted Stat	•
Baitimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23s or 28s-7 show we bring to other training or other training or thems 23s or 28s-7 show	d by Funeral	11. N	Marital Status	ed 2 Married		edent Ever in lorces? 2000		Was Deceder If Yes, specify		nic Origin Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Americ Black, White, SpecifyBlac	etc.
215-( ithin 72 h nan "natu	Completed	Ele	(Speci ementary/Secon	15. Decedent's E ify only highest gr ndary (0-12)	ade completed)	(1-4or 5+)	(Give	dent's Usual ( kind of work DO NOT use	done durin retired)	ng most o	f working		(ind of Business/In	
and 21 Ibe filed w ntal Hygien ed other ti	Re Co	17. F	12th ather's Name (Ambatc)	First, Middle, Lasi hew Ge	ses		Insu	rance	18.	Mother's	Name (First, Mide ubrehan		•	
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Baitimore, permit. Pages 1 an Department of Heal Important: if item 2		20a. I	Method of Disp		☐Removal from	20b. State	Place of Dispo	natory or other	of or place)		11 thersby Date /3/2004		20886 ocation - City or To	
Baitin permit. P Departme importan	DUCE.		-	neral/Service Lice		n san	te of H	. Name and	Address of	Facility			ver Spri 2001 ngton D.(	
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Vision of Attending Physical death.	ation. T	1	Manner of Death Manuer of Death Matural Accident		28a. Date (Mor		28b. Time of Injury		Injury at Work?	2  No	28d. Describ			7
Division of within 24 hours after death. To the Funera after death. To the Funera Director: After the formulate in the funeral princed.	Certification.	3 4	S Suicide	6 Could not be determined	280. Place	e of Injury - At h ling, etc. (Spec	nome, farm, str	eet, factory, o	ffice		28f. Location City or	(Street ar Town, State	nd Number or Rura a)	l Route Number,
hs Hospit n 24 hour he Funera	pletery min	29a.	Certifier (Check only one)	1 XCertifying P 2  Medical Exa	miner: On the b	e best of my kn basis of examin oner stated.	owledge, death ation and/or inv	occurred at restigation, in	he time, d my opinio	late and p	place, and due to the control occurred at the time	ne cause(s) e, date and	) and manner as st d place, and due to	ated. the cause(s)
= = = 5	2	29b.	Signature and t	title of certifier	٨	0	0	29c. L	icense nui	mber		29d. Da	te signed (Month, i	Dev. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** 2004 1:50 March /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) Examiner Baltimore Cit HOSPITA N/A Johns Hopkins If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days **Funeral** 1□M 2 F Yrs. Virginia Director None Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 shours at the page of the page o 1 Yes 2 No Prince William Woodbridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22191 2783 Burrough Hill Ln. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Black Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) None None 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shawnequa Alexis Albert Kraig Alleyne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kraig Alleyne / 2783 Burrough Hill LN,Woodbridge, VA 22191 Father Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Stafford Memorial 04-01-2004Stafford, Va ⁴ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Miller Funeral Home 21. Signature of Funeral Service Licensee 3200 Golansky Blvd, Woodbridge, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospitel or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria by Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ZNo 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 NO 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 21 No certificate 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

APR

32. Registrar's Signature

2004

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** BENJAMIN APRIL 2, ADELMAN 4:30 P 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4211 COLIE DRIVE SILVER SPRING MONTGOMERY 8. Date of Birth (Month, Oay, Year) SEPT 19, 1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 **X** M 2 □ F NEW YORK 90 578-24-3528 1913 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examiner must be natified at 1 ☐ Yes 2 ☐ No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4211 COLIE DRIVE 20906 UNITED STATES or Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Importent: If tem 27 is marked other than "natural; or tha any finlury or other treumatic event, It a Medical Escritical Yes 2 □ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. à 3 ₩idowed 4 Divorced Year or Dates: WWT T WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) PERSONNEL ADMINISTRATOR FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BARNETT **JACOB ADELMANN** TESSIE GAFFIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAUL ADELMAN, SON 1434 FAIRFIELD AVENUE, CHARLESTON, SC 29407 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2-☐ Cremation 3 ☐ Removal from State 5 Other (Specify) ` 4 □ Donation MT. LEBANON CEMETERY 4/4/04 ADELPHI, MARYLAND 21. Signature of Funeral Pervice Li ense DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. Jun 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part 1. Approximate shock or heart failure Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE CORONARY SYNDROME /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, any loading to minaday cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a cons « juence of : Examiner slcien and burial-transit the death certificate be executed Due to (or as a consequence of): the attending physicien hed for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for Year Month in the past 12 months? Day 5 Other (specify) 4 Pregnant at time of death P.O. ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. þ The law requires 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No 2 XNo 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XYes 2 No Other: 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this s after death.
I Director: After this
of in by the funeral d 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide 24 hours 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Shons D14876

State Registra

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APR

31. Date filed (Month, Day,

SURESH C. GUPTA, M.D.,

0 5 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

4701 RANDOLPH ROAD, ROCKVILLE, MARYLAND

APRIL 2, 2004

	1 - For State Registrar		Maryland / Dep	artment of H rtificate of L		R	eg. No. 2 (	004 1266
Physiciar /Medica Examine	RORRA	D.	ADAMS	4b. City, Town, or	Location of Dea	2. Date of Deat Month April	Day	Year OG OG Month of Death
Funeral Director	Peninsula Reg. 5. Social Security Number 220–32–8004	IONAL Medic	//	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birthplace (State or Foreig Country) MARYLAND
Baltimore, Maryland 21215-0036 permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other freumetic event, the Malfall Examiner must be notified at once.	501 SOUTH  11. Marital Status  1 Never Married 2 Nover  3 Nover Married 2 Nover  15. Decer  (Specify only high  Elementary/Secondary (0-12)	MAIN STREET    12. Was Deceration   12. Was Deceration   12. Was Deceration   14. Was Deceration   15. Was Decerat	2 (Ž) No les:    16a. Dece (Give life.)   REC   ADAMS   SR.     19b. Maili   501   tate   20b. Place of Disprementary, cree   EVERGREE	Was Decedent of Hill If Yes, specify Cubar I Yes 2 No  dent's Usual Occupa kind of work done of DO NOT use retired, GIONAL MAN  ang Address (Street a SOUTH MAI sition (Name of matory or other place N CEMETER 2. Name and Addres	spanic Origin? (5 n, Mexican, Puer Specify:  (tion uring most of wo United Markets Na ANNI ANNI ANNI ST.,  (S) (S) (S) (S) (S) (S) (S) (S) (S) (S	Specify Yes or No- no Rican, etc.)  orking  me (First, Middle, M E S  ural Route Number, BERLIN, M Date	PEST ( Maiden Sumam OMMERS City or Town, ARYLANI 20c. Location -	A a American Indian, k, White, etc.  WHITE siness/Industry  CONTROL  e)  State, Zip Code)
fillcate be executed ifficate be executed g physician and as the burial-transit as the burial-fransit	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	used the death. Do not en ch line.  If as a consequence of):  If as a consequence of):  If as a consequence of):	SEPSIS  C-dyf a		c or respiratory arre	st,	Approximate Interval Between Onset and Death  3 clays
wrequires that the death car is been signed by the attending should be detached for use		1 ☐ Live bir 4 ☐ Pregna 9 ☐ Unknor	nt at time of death 5[ wn	Ectopic pregnancy Other (specify)	n in Part I.	1 ☐ Ye	Mor acco use contr s 2 12/No	e of delivery with Day Year sibute to the cause of death? 3 Probably 4 Unknown where autopsy findings availabilition to completion of cause of
VISION Of VITA Attending Physicien: It death. actor: After this cartificator. It is the funeral director.	25. Was case referred to medexaminer?  1  Yes 2 No  27. Manner of Death  1  Watural 5 Per 2  Accident inve 3  Suicide 6 Cou 4 Homicide	Hospital: 1 2 In Indiang Indiang Indiang Indiang Indianated Indian	patient 2 ☐ ER/Outpatien Injury Day Year)  of Injury - At home, farm, sti g, etc. (Specify)	f 28c. Injury Work M 1 1 Y	r: 4 □ Nursing H at ? 'es 2 □ No	perform 1 Yes 2 ath (Check only one Home 5 Reside 28d. Describe ho 28f. Location (Str. City or Town	ned? d    No 1	eath?  Yes 2 No  or (Specify)  and  or or Rural Route Number,
To the Hospital or within 24 hours after To the Funce after Completely filled in completely filled in	30. Name and ordress of pers U.S. Na. Natesen 14	in the baland manner on the baland manner of the second manner of the se	sis of examination and/or in er stated.	29c. License	number	urred at the time, da	ete and place, a	(Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 100 L 12669 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 11:47 AM April AMOS CLESTON LeROY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Havre de Grace Harford Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 2/18/1938 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 212-38-4442 66 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Forest Hill Harford MD. 10g, Citizen of What Country? 10e. Street and Number 10f Zin Code 21050 U.S.A. 402 Carrollton Court natural', or Items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces2 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United Maryland 2121 Elementary/Secondary (0-12) Coilege (1-4or 5+) States Army Diesel Mechanic 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Suld be f permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic evoluse. Is marked Helen Arthur Cleston Amos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 402 Carrollton Court Forest Hill. Md. Mary F. Amos /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Highview Mem. Gar. 4/15/2004 Fallston, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungeral Service Vicensee 22. Name and Address of Facility Jarrettsville, Maryland Kurts & Son Funeral Home, P.A. wo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2 minutes Physician muocardia /Medical Due to (or as a consequence of): Examiner COPOPARY (Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records, Yes 2 No 3 Probably 4 Unknown Inoldemio Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 26. Place of Death (Check only one) 25. Was case referred to medical # Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 1 Natural 2 Accident 5 🗌 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 🗌 Homicide within 24 hours a To the Funeral C completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 34208 Lendo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) APRE TTSVILLE KD, MRRETTSVILLE, MD 2/084 32. Registrar's Signature 31. Date filed (Month, Day, Yeer) 2004 Registrar

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Baltimore, Maryland 21215-0036	d 2 should th and Men 7 Is marke traumatic	. 8	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Str	reet and Num	ber or Rui	al Route Numbe	r, City or To	wn, State, Zip	Code)
Σ.	and and m 27		Susan D. Boward	- Mother					gerstow			21742
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	Dhusisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physici /Medic		Theodore Edward Balenger	J	anuary 1	6,2004 714 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			37760 Mohawk Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Charlotte Hall  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	St. Mary's  9. Birthplace (State or Foreign
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36	be filed within 72 hours after death with the Maryland hat Hyglene. od othar than "natural", or Items 23a or 28a-1 show event, the Mcdical Examinar must be indiffied at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ ☑ vorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give ⚠ Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R</li> <li>Yes 2 N No Specify:</li> </ol>	city Yes of No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
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	To the Hospital of within 24 hours at To the Funeral D completely filled it	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, ar	nd due to the cause	e(s) and manner as stated.
)	To the within To the comp	M	29b. Signature and title of certifier  M. H	29c. License number	29d.	Date signed (Month, Day, Year)  1/17/2004
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middle, Last) 2. Data of Death Day Month Yaar **Physician** 25\_ 2004 11:03 p.m. Eva Forrest BONEBRAKE March /Medical 4a Facility Nama (If not institution, give streat and number) 4b. City. Town, or Location of Daath 4c. County of Death Examiner Williamsport Nursing Home Williamsport Washington If Under 1 Year 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) If Undar 24 Hrs 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F Yrs. Director 223-12-3392 91 Feb. 3 1913 Virginia Usual Residence of Decadant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1X Yas 2 □ No Directo Maryland Washington Hagerstown 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code Funerai 876 Pine Street 21740 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forces? 1 □ Yas 2 ☒ No if Yes, Giva Yaar or Datas: 11. Marital Status 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: Specify: Completed by 3 ☑ Widowad 4 ☐ Divorced White 15. Decedant's Education (Specify only highast grada completed) 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) 16b. Kind of Business/Industry ei Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) 8 0 Packed soles Shoe manufacturer 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be permit. Peges 1 end 2 should Depertment of Heelth end Men John William Funk <u>Mallie Elizabeth Vaughan</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Numbar or Rural Route Numbar, City or Town, State, Zip Coda) Important: If Item 27 is any injury or other tra pace. Shirley Parker - Niece 18231 College Road Hagerstown, Md. 21740 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 3/29/04 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Minnich Funeral Home red I. Vest 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical cerebrovascular accident Examiner Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate causa. Entar Undarlying Causa (Disaasa or injury that initiated avants Dua to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consaguanca of) rasulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha cause of death? 1 ☐ Yas 2 No 3 Probably 4 Unknown dichetes mellitus Completed by Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? atrial Fibrillation congestive heart Failure 1 1 Yes 24/10 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Unursing Homa 5 Rasidance 6 Othar (Spacify) 2 1 Yes 2 No 3 DOA After this funeral of 27. Manner of Daath 28a. Date of Injury (Month, Day Yaar) 28b. Time of 28c. Injury at Work? 28d. Describa how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yas 2 ☐ No investigation I Director: A 2 Accidant 6 Could not ba 3 ☐ Suicida 28f. Location (Straat and Number or Rural Route Number, City or Town, State) ò 28e. Place of Injury - At home, farm, straet, factory, offica building, etc. (Specify) 4 - Homicide within 24 hours e To the Funerel C completely filled edical 1 Certifying Phyaician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signatura and title of certifian 29c. Licansa number 29d. Date signad (Month, Day, Year) Cynthea Kutaner-Sand no D47451 March 26,2004 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Custos Kithor - Sands MD W. Illiams port Nursing Home, 154North Artizan Street Cynthia Kuttoria. 31. Data filad (Morn, D. V. Yan) Sands ND Williamsport Maryland 21795 32/Registrar's Signature 2004 rested State

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State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month **Physician** 2004 Ruth Lois BAKER March 28, 1:05 p. M /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Homewood at Williamsport Williamsport If Under 1 Year | ff Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) May 5, 192 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛛 F 79 212-20-4003 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show Examiner must be nutified at 1 ☑ Yes 2 ☐ No Maryland Washington Hagerstown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 21740 USA 38 East Irvin Avenue Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", or by Specify 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) homemaker her own home 12 n permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths any injury or other traumeth 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ethel Brittain Robert Ebert ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18928 Orchard Terrace Road, Hagerstown, Md. 21742 Bruce E. Baker - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/1/04 Rest Haven Cemetery Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatur and Formeral Service Licenser 23. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. anuel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to intrincidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown á signed 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. peq 2 🗆 No 3 Probably 4 □Unknown Yes peeu ( 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Other: Hospital: 2**%** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 🗌 Yes Siu within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral: 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of eerstig who completed cause of death (Item 23a) (Type, Print) 31. Date filed State Registrar

			1 - For State Registrar	State of Ma	ryland / Depa	artment				1	Reg. No. 2	004	12674
	Physici	an	Decedent's Name (First, Middle, Last)     A = -1 - 2 - 3	Danish	T					2. Date of Dea Month	Day	Year	3. Time of Death
1	/Medi	cal	AΓCΠ1E  4a. Facility Name (If not institution, give s	Bennett .	Jr.	4h City	Town or	Location of		March		004 unty of Death	5:05 P. <sup>™</sup>
1	Examir	ner	Kline Hospice H			1	It. A		Death			ederi.	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under	1 Year	If Under 2	24 Hrs. [	3. Date of Birt			oplace (State or Foreign
	Director		225-34-1808 <sup>1X</sup>	M 2 🗆 F	71 Yrs.	Months	Days	Hours	Min, M	B. Date of Birt (Month, Day arch 1	9,1933	Vi	rginia
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City. Town or Lo	ncation						-	10d. Inside City Limits
	Aaryla I sho	ō	Md. Freder:			cy Rid	lge						1 ☐ Yes 2 No
	28a-	rect	10e. Street and Number			10f. Zip	Code			T	10g. Citizen	of What Co	untry?
	3a or	Ī	9915 Rocky Ridge R	d.			217	778				U.S.	•
	death	Funeral Director	11. Marital Status	2. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spec	ify Yes or No- ican, etc.)	14. 1	Race - Amer Black, White	
98	or the	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🕅 No If Yes, Give	)	1 ☐ Yes 2		Specify:	, 1 001011	ouri, 6(0.)		ecify:	White
Š	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show the Medical Exprise or must be restilled at	ed by	3 ∰ Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	16a Dooo	dent's Usua	LOggia	tion.					
75	in 72	Completed	(Specify only highest grade	completed)	(Give	kind of wor DO NOT us	k done a	urina most	of working	7	16b. Kind o	f Business/li	ndustry
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b	e filed val al Hygie I other t vent, I	Be C	17. Father's Name (First, Middle, Last)							First, Middle,	Maiden Sun	name)	
yla	should be and Mental amarked o	Jo I	Archie Bennett S	r.				Jar	nie B	ooth			
Maryland 21215-0036	and and is m		19a. Informant's Name/Relationship (Typ			-				Route Numbe		wn, State, Zi	ip Code)
	s 1 and of Health item 27 other tr		Brenda Williams (D. 20a. Method of Disposition	aughter)	13706 20b. Place of Dispo			l. Thu	1rmon	t,Md.		on - City or T	Own State
Baltimore,			1 ☐ Burial 2 K Cremation 3 ☐ Re	moval from State	cemetery, crei	natory or ot	her place		arch	29		sburg	
Ħ	+ 5 4 5		' 4 Donation 5 ☐ Other (Specify)  21. Signature of Funcial Service License	0	1	2. Name and			/ 1				
ä	Department of the sany once		Veryin 7	Han					Ι,	2525 Br mithsbr	radbur	y Ave	• 03
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line	he death. Do not ent	er the mode	of dying	, such as c	cardiac or i	respiratory arr	rest,		Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):								
P.O. Box 6	it the death certific by the attending p tached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	Ectopic pre Other (spe						Date of deliv Month	ery Day Year
Vital Records, F	w requires that been signed should be del	ρ		TVE PULL	you Ary &	nderlying ca ) SEA-8		n in Part I.		23e. Did to			he cause of death?
9	e law req has beer je 2 shou	Completed	CONGESTIVE HEARY	PATLO	RE					24a. Was a		b. Were auto	opsy findings available
<u> </u>	The laste has page	Con	CHROMIC ATRIAL	FIBRIL	LATION.	HEN	rote	MICI	AMEMIA	perform 2+□ Yes		death? 1 ☐ Yes	2 No
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of	Attending Physician: r death. ector: After this certifica	atlon; To	1 Yes 2 No Proceed No. 1 Yes 2 No. 1	28a. Date of Injury (Month, Day	t 2 ER/Outpatien 28b. Time of Injury		c. Injury Work	4 Li Iquis	280	5 ☐ Reside	-	ther (Special curred	(y) Fourt
Division	in Die	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory,	office		281	Location (St City or Town		mber or Rura	al Route Number,
	To the Hospital or within 24 hours after to the Funeral Director completely filled in	Medical	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of er: On the basis of e and manner state	xamination and/or inv	estigation,	in my op	inion, death	place, and occurred	at the time, d	ate and plac	e, and due to	o the cause(s)
_	Vith Com	2	29b. Signature and title of certifier	1. OConn	an so	29c.	License 2	number 3176	/	2	9d. Date sign $3/2$	ned (Month,	
2			30. Name and address of person who con Brigal M, d'CeNA	lop no	th (Item 23a) (Type, 50/ W,	Print) SEVEN	VH	87,	, Fo	REDER	RICK	MD	21701
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			For State Registrar	State o	of Marylan	-	artmen rtificate				lental Hy	giene	Ur	12675
	Dhysiei	on	1. Decedent's Name (First, Middle,								2. Date of De		Year	3. Time of Death
	Physici /Medio	cal	Brenda Joy				41 00	-		(5)	APKIL	.517	004	1-434M
	Examir	ier	4a. Facility Name (If not institution, Doctors H	-	mber)		4b. City,		r Location o Lanha			4c. Count	-	George's
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			place (State or Foreign intry)
	Director		577-64-4783	1□ M 2□XF	57	Yrs.	Months	Days	Hours	MIRT.	Nov. 2	7, 1946	Wa	sh., DC
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	, Town or Lo	ocation							10d. Inside City Limits
13	a-f sh	ctor	Maryland Princ	e George	s		Lanl	nam						1 X Yes 2 No
2	or 28	Direc	10e. Street and Number		· · · · ·		10f. Zip					10g. Citizen of	What Cou	ntry?
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1	r Item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	Armed Fo	orces? 2∭XNo	1					ecify Yes or No Rican, etc.)	Bla	ick, White,	, etc.
4 50	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ve lates:		1 Yes	2[X] No	Specify:			Specia	у: В:	lack
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99	Mal y all of the fill of the should be fill the and Mental High and Marked of the marked of the traumatic even		19a. Informant's Name/Relationsh Reginald F. Br		lusband							er, City or Town		0774
. 8	of Hear		20a. Method of Disposition	2 🗆 🗆		lace of Dispo	sition (Nan	ne of	Ţ		ate	20c. Location		own, State
Du	Page ment mant: If	1	1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	Har	mony N	1emori	lal I	Park			Lan		
Bus	Partition of the property of the property of the property of the pages 1 and 2 should be filed within 72 hours after death with the Marylan Depaitment of Health and Mental Hygiene.  Depaitment of Health and Mental Hygiene.  Depaitment of Health and Mental Hygiene Institutely, or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner mast be notified at once.		21. Signature of Funeral Service L	icensee	+ 111	22	2. Name an					Funeral Wash.,		
ه			23a. Part1. Exter the disease, or o	complications that	aused the death	n. Do not ent							DC 2(	Approximate
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	/Medical Examiner		resulting in death)	a	(or as a consequ	ience of):								
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4	Attending Physician: The law requires that the death certificate redeath.  actor: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	ed by										Yes 2□No		
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C d shacond lettive a relativity	lor Att after d Direct In by	Certification:	3 Suicide 6 Could not determine	288. Place	of Injury - At ho ing, etc. <i>(Specif</i> )	me, farm, str	eet, factory	, office		2	28f. Location (3 City or Tox	Street and Numb vn, State)	er or Rura	al Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his After this certificate his physician of the Funeral director, page	Medical C	29a. Certifier (Check only one)  Certifying 2 Medical E	Physician: To the xaminer: On the b	a best of my knor asis of examinat ner stated.	wledge, deatl	h occurred a	at the tim in my op	ne, date and pinion, deat	d place, a th occurre	and due to the ad at the time,	cause(s) and ma date and place,	and due to	tated. the cause(s)
	To the	Me	29b. Signature and title of certifier	7	41-0				number			29d. Date signe	d (Month,	Day, Year)
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			30. Name and address of person w	tho completed caus				Vec-	- 6.	77- 3	35/ /	AUKEL,	MO	207017
	Sta	ate	31. Date filed (Month, Day, Year)	32,5	Registrar's Signa		M/N 31	KC21	207	76 5	, , , , , , , , , , , , , , , , , , ,	· - ace,	,	/- /-/
	Registi	rar	APR 097	2004	elus de	1. Ago	noke							

Dhygici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	No. 2004 Day Yeer	3. Time of Death
Physici /Medic		Steven Darnel	<u> </u>					, 2004	9:52a
Examin	er	4a. Fecility Name (If not institution, give s	treet and number)			Location of Death		4c. County of Death	
		5521 Rollins Lane 5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)		l Heights If Under 24 Hrs.	8. Date of Birth	Prince Ge	
uneral irector		578-82-5407 X Usual Residence of Decedent	M 2□F 33	Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ear) Cour 1970 Washi	place (State or Fore ptry) .ngton,DC
Department or result and wonter regions.  Department of region 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic avent, it a Medical Examiner must be notified at once.	Director	10a. State 10b. County  Maryland Prince Ge  10e. Street and Number		Town or Lo	leights				0d. Inside City Lim
l ber	Dir	5521 Rollins Lane			10f. Zip Code 20743			Citizen of What Cour	•
ms 22	Funeral		2. Was Decedent Ever in U.S	3. 13.1		spanic Origin? (Spe n, Mexican, Puerto		nited Stat	
ral', or Ita	by	1 💢 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2ሺ No	n, Mexican, Puerto	Rican, etc.)	Specify: Blac	
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d of	Be	17. Father's Name (First, Middle, Last)	auch				(First, Middle, Mai	•	
mark	2	Gilbert Preston B  19a. Informant's Name/Relationship (Type		19h Mailin	n Address (Stract		ndria Col	e ty or Town, State, Zip	Code
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itam (	1	20a. Method of Disposition	20b. Pla	-	sition (Name of natory or other plac		-	. Location - City or To	
ry or		ty Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	mioval nom State			? Park 4/7/0	)4 La	ndover, Ma	rv1and
Importa any inju once.		21. Signature of Funeral Service License		22 A	Name and Addres	s of Facility S. Pope 1	Funeral H		
频		23a. Part1. Enter the disease, or complice shock or heart failure. List only on	ations that caused the death.					rie, riu. Z	Approximate Interval Between
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ng pe	by	Part II. Other significant conditions cont	ributing to death but not result	ting in the ur	iderlying cause give	n in Part I.		o use contribute to the	
should	ete						24a. Was an		
certificate has rector, page 2 a	e Completed	25. Was case referred to medical					autopsy performed 1 ☐ Yes 2 🔯	nrior to com	sy findings availal apletion of cause of 2 No
is certific director,	O B	examiner?	_ ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3□ DOA Othe	26. Place of Death		6 □Other (Specify	,
After th funeral	ation: T	27. Manner of Death  1X Natural 5 ☐ Pending  2 ☐ Accident investigation		28b. Time of Injury	28c. Injury Work	at 2	8d. Describe how in		)
al Director: ad in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office	2	8f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
To the Funeral I	edical	29a. Certifier (Check only one) 1⊠ Certifying Physic 2 Medical Exemination	cian: To the best of my know er: On the basis of examinatio and manner stated.	ledge, death on and/or inv	occurred at the tim estigation, in my op	e, date and place, a inion, death occurre	nd due to the cause d at the time, date a	(s) and manner as sta and place, and due to	ated. the cause(s)
To the complet	ž	29b. Signature and title of certifier			29c. License	number	29d. I	Date signed (Month, D	Pay, Year)
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			For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of He		, ,	ene	1000	
	Physici		1. Decedent's Name (First, Middle, Inc.)  Doretha Br	Last) OWn			V-3	2. Date of Death Month March 21	Day Year	3. Time of Dealin	
	/Medio Examir		4a. Facility Name (If not institution, g		er)	4b. City, Town, or L	ocation of Death	march Zi	4c. County of Death	12:30am	
		Ш	University of MD	Specialty	y Hosp	Baltimo				1	
	Funeral Director		5. Social Security Number 6 579-88-3037	. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. last birthday, Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y			
			Usual Residence of Decedent	21	35 Trs.			9-30-68	Wash	ington DC	
	ylanc how	erai Director	10a. State 10b. County		10c. City, Town or L	ocation			10	0d. Inside City Limits	
	e Mau		DC		Washingt	on DC				tx Yes 2 □ No	
	ith th		10e. Street and Number			10f. Zip Code		10g	. Citizen of What Coun	try?	
	s 23s		1111 lst St N.			20001			nited State		
	Itam Inerr	Funerai	11. Marital Status  11XXNever Married 2 ☐ Married	12. Was Decede	s?	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spo Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e		
936	urs at		3 ☐ Widowed 4 ☐ Divorced	I 1 ☐ Yes 27 If Yes, Give Year or Date	s:	1 ☐ Yes 2X No	Specify:		Specify: Bla	ack	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28e-1 show eumatic event. If a Medical Evantraer must be notified at	To Be Completed by	15. Decedent's (Specify only highest of	Education	16a, Dece	dent's Usual Occupati	on	16	b. Kind of Business/Ind	ustry	
2	ithin ne.		Elementary/Secondary (0-12)	College (1-4	or 5+)	kind of work done dui DO NOT use retired)		ng			
2	filed wi Hygien other th ant, I's		12		E	Bus Attenda			DC Shools		
auc	f be fi		17. Father's Name (First, Middle, La	St)		1.		e (First, Middle, Ma	iden Sumame)		
2	should be and Mental s marked o umatic eva		Freddie Brown 19a. Informant's Name/Relationship	(Type Print)	10h Maili	ng Addross (Street no		la Ellis	ity or Town, State, Zip		
<u>8</u>	s 1 and 2 should f Health and Men itam 27 is marke other treumatic		Viola E. Ellis								
Baltimore,	s 1 and 2 f Health itam 27 l		20a. Method of Disposition		20b. Place of Dispo	osition (Name of			on DC 2000]		
Ë	Page: ient o nt: If ry or		1 XBurial 2 ☐ Cremation 3  3 4 ☐ Donation 5 ☐ Other (Spec		le	matory or other place) t Cemetery	3-30-		Washington		
aĦ	permit. Pages 'Department of I Importent: If its any injury or ot		21. Signature of Funeral Service Lic			2. Name and Address Alexan			washington	DC	
n	90 = 80		Wax 8	1/ the	e l	2617 Penn.	Ave S.E.	ope Funer. Washing	ат ноте ton DC 2002	20	
	Pnysician <sub>I</sub>		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	i line.	ter the mode of dying,	such as cardiac c	or respiratory arrest		Approximate Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	aSeps	as a consequence of):						
	Examiner	Physician/Medicai Examiner	Sequentially list conditions, if any, leading to immediate	any, leading to immediate							
	icate be executed physician and s the burial-transit		Cause (Disease or injury that initiated events resulting in death) Last	(Disease or injury Lated events End Stage Renal Disease							
8/60,	cate be e				hyroidism						
χ Q	ding p		IF FEMALE:	23c. If yes, outcon	ne of pregnancy						
O. BOX	at the death certifii I by the attending parached for use as		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth	2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deliver	y Day Year	
7.	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23a Did tobac	cco use contribute to the cause of death?		
cords,	w requires that been signed b should be deta	ed by							2 □ No 3 □ Proba		
ā)	law as b 2 st	ompieted						24a. Was an	24b. Were autop:	sy findings available	
	T ate	Con						autopsy performed 1 Yes 2	l? death? No 1 ☐ Yes 2	sy findings available pletion of cause of	
	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					(Check only one)			
	S w F	2	1 Yes 2 No	Hospital: 1 🕅 Inpa		it 3 DOA Other:	4 Nursing Hon	ne 5 🗆 Residence	e 6 □Other (Specify)	***	
	ding Ph. h. After thi funeral	Certification;	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Ir (Month, I	ojury 28b. Time of Day Year) Injury	28c. Injury at Work?	2	28d. Describe how i			
	teat feat for: the		3 ☐ Suicide 6 ☐ Could not	estigation M 1 Tyes 2 No				28f. Location (Street and Number or Rural Route Number.		S	
2	ital or Attanding First after death.  Tal Director: After led in by the funer.		determined determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)			eet, ractory, office		City or Town, S	t and Number or Hural I tate)	Route Number,	
	To the Hospitel or Attent within 24 hours after deatt To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exa	Physician: To the beaminer: On the basis and manner	st of my knowledge, death of examination and/or in- stated.	n occurred at the time, vestigation, in my opini	date and place, a on, death occurre	nd due to the cause od at the time, date	e(s) and manner as stat and place, and due to t	ted. he cause(s)	
	To tha within 2 To the complet	N	29b. Signature and title of pertifier			29c. License nu	umber	29d.	Date signed (Month, Da	ay, Year)	
			· Maria	00		25247	74	Ap	ril 2,2004		
	(2)		30. Name and address of person who			•					
	Sta	e	601 South Char 31. Date filed (Month, Day, Year)		1timore,MD 2	21230					
	Registra		APR 0 7 2004		k for	e.					

	1 = For State Registrar	State of Maryla	and / Depa	artment of Hea rtificate of De	alth and Meath		neg. No.	4 12678
Physician	Decedent's Name (First, Middle, La     CELESTINE		BARNES			2. Date of Dea Month APRIL 3		3. Time of Death 12:30 A. M
/Medical Examiner			DAIME	4b. City, Town, or Loc		MINIE J	4c. County of De	
	WASHINGTON ADVEN	TIST HOSPITAL		TAKOMA			MONTGO	MERY
Funeral Director	5. Social Security Number 6. S 577-34-5866  Usual Residence of Decedent	6ex	rs. last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birt	y 26 WAS	Birthplace (State or Foreign Country) SH., DC
yland	10a. State 10b. County	10c. (	City, Town or Lo	ocation				10d. Inside City Limits
beath with the Marylar ns 23a or 28a-1 show must be notified at	MD PRINCE	GEORGE CA	APITOL H	HEIGHTS				1 Ves 2 □ No
with the secretary		n 0011m11 //005	-	10f. Zip Code			10g. Citizen of What	
offer death virter death virter death virter 234	1207 ADDISON ROA	12. Was Decedent Ever in		20743 Was Decedent of Hispar If Yes, specify Cuban, M		ecify Yes or No-	U. S. A.	nerican Indian,
OUGGO  hours after death with the Maryland tural; or Itams 23a or 28a-1 ahow all Examinat must be notified at ad by Funeral Director		Armed Forces? 1 ☐ Yes 2 A No If Yes, Give		v	Mexican, Puerto I Specify:	Rican, etc.)		
D-0036 72 hours at natural; or died Exem		Year or Dates:	1				Specify: BI	
21215-0 ed within 72 ho ygiene. her than "natur t, the Wed call t, completed	(Specify only highest gra  Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of workii	ng	16b. Kind of Busines	ss/Industry
filled will Hygiene other the ont, the	12TH GRADE		NUF	RSES ASSIST	ANT		DEPT. OF I	HUMAN RESOURCE
De fil dott dott Be	17. Father's Name (First, Middle, Last,				MARY M.		Maiden Sumame)	
Should not Men of Men o	19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Street and i				Zin Code)
C = 01 F	DORIS E. THOMAS	SISTER		HARBOR TO				
altimore, mut. Pages I ar partment of Hea portent: If item: y injury or other	20a. Method of Disposition 1   Burial 2 Cremation 3		. Place of Dispo cemetery, crer	sition (Name of natory or other place)	D	ate	20c. Location - City	or Town, State
Haltimor	`4 ☐Donation 5 ☐Other (Specif	y) <u>M</u>		ET CEMETER			WASHINGTON	
any is on a	21. Signature of Funeral Service Licer	3 1		2. Name and Address of 24 - 8TH ST				
A STATE OF THE PARTY OF THE PAR	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	C. Lawrence Co.					Approximate
Physician	Immediate Cause (Final disease or condition	a. Pu-Insider	0 /	andalis	-			Interval Between Onset and Death
/Medical Examiner	resulting in death)	Due to (or as a conse	equence of):	nbolism Tory D				
e e	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	AL equence of):	15 ry D	ISGASO	G-		
	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	DEED	de	Tiller	her c			
	resulting in death) Last	Due to or as a conse	equence of):		No. Chall & had			
cate be e physician the burit		. d						
certificatif	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregi	nancy				23d. Date of d	olivon
death death sed for u	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
d by the letache	9 Unknown	9□ Unknown						
ecords, P.O law requires that the as been signed by th 2 should be detach in pleted by Phys	Part II. Other significant conditions of	ontributing to death but not re	esulting in the ur	nderlying cause given in	Part I.	23e. Did to	د ـ د	to the cause of death?  Probably 4 □Unknown
ecords, law requires las been signe 2 should be						24a. Was a		
# 8 # 8 F						autops	sy prior to med? death?	
VITAL icien: T certificate ector, pa	25. Was case referred to medical examiner?			26.	. Place of Death		2 <b>X</b> No 1 ☐ Ye	s 2 No
Or VITA Physicien: this certific ral director, To Be (	1 ☐ Yes 2 No		☐ ER/Outpatien	t 3 DOA Other: 4	4 Nursing Hom	ne 5 ☐ Reside	ence 6 □Other (Sp	ecify)
ding ding the After funer	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Work? 2 Accident investigation M 1 Yes 2 No							
bivision of the or Attending F is after death.  al Director: After ed in by the funer.  Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I	home, farm, stre			8f. Location (Si	treet and Number or F	Rural Route Number,
rs after all Direct of in Cert	4   Homicide	building, etc. (Spec	ary)			City or Town	n, State)	
To the Hospitel or Attending Physicien: Whithis 24 hours after death To the Funeral Director. After this certific completely filled in by the funeral director.  Medical Certification: To Be C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exan	ysician: To the best of my kn niner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the time, da restigation, in my opinior	late and place, a on, death occurre	nd due to the cad at the time, d	ause(s) and manner a late and place, and du	es stated. e to the cause(s)
within S To the comple	29b. Signature and title of certifier	- State of States.		29c. License nun	mber	2	9d. Date signed (Mon	th, Day, Year)
	Stun T.	u		241.9	998		9001 2	2004
(10)	30. Name and address of person who	completed cause of death (Ite	эт 23а) (Туре.	Print)			prat o,	2004 ns. 20782
State	DR. STEVEN 7 31. Date filed (Month, Day, Year)	32. Registrar's Sign	ST HA	no How 31	1. 7/	Hyaz	Visulle, r.	ns. 20782
Registrar		004	15 1	mile				

			For State Registrar	State of Maryland	d / Depa	artment of He rtificate of D	ealth and Neath	Reg	ene 200			
	Physicia /Medic Examin	al .	1. Decedent's Name (First, Middle, Last  Rosie Brue  4a. Facility Name (If not institution, give	Street and number)		4b. City, Town, or L	ocation of Death	2. Date of Death Month April 3	4c. County of Dea			
	Funeral Director		175-32-9351		V	Silver S If Under 1 Year Months Days	Spring If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) 12-23-1	Montgome (eer) 9. Bir 936	ery thplace (State or Foreign ountry) S C		
e, Maryland 21215-0036	death with the Maryland ms 23e or 28e-f show rmust be notified at	ctor	Usual Residence of Decedent  10a State 10b. County	10c. Çin W ê	/ Town or Lo shin	gton				10d. Inside City Limits 1 ☐ Yes 2√2 No		
	h with th	al Dire	10e. Street and Number 631 Gallatin S	t. NE		10f. Zip Code 2 0 0	17	109	g. Citizen of What Co USA	ountry?		
	be filed within 72 hours after death with ital Hygiene. id other than "natural", or itams 23e or swent, its Medical Examiner must be a swent, its Medical Examiner must be a	by Funeral Director	11. Marital Status  1 Never Married 2X Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes ( No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🖾 No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:			
	filed within 72 ho Hygiene. ther then "netur ent, Itse Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) 16a. Dec (Gir (Gir (College (1-4or 5+)		dent's Usual Occupation kind of work done during most of working DO NOT use retired) Iinister			b. Kind of Business/Industry  Private			
		To Be C	17. Father's Name (First, Middle, Last)  Jacob Hill				Elease	e (First, Middle, Ma Robins	on			
	2 2 2 2		19a. Informant's Name/Relationship (7) Bennie Glasco/		1	ng Address <i>(Str</i> eet an Gallatii				Zip Code) DC 20017		
	Pages 1 and nent of Health int: If itsm 27 iry or other tr		20a. Method of Disposition  1 Burial 2 Cremation 3 1  4 Donation 5 Other (Specify	20b. P	ometery cre	osition (Name of matory or other place, d. Cemete:	,	Date 20	ashingt	Town, State		
Balti	permit. Pages Department of I Important: If its sny injury or of		21. Signature of Funeral Service Licens	les	1		h Capit	ol St.	NW Wash	Home ington DC Approximate		
760,	Physician / Medical Examiner	Ilcal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
	Hospital or Attending Physician: The law requires that the death certificat 24 hours after death. Funeral Director: After this certificate has been signed by the attending phytial fined in by the funeral director. page 2 should be detached for use as the lift of the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year					
	quires that t n signed by uld be detac	by	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	inderlying cause giver	n in Part I.			Month Day Year  use contribute to the cause of death?  □ No 3 □ Probably 4 ☑Unknown		
	ician: The law requir certificate has been si rector, page 2 should I	Completed						24a. Was an autopsy performe 1 🗆 Yes 2 🕻	sy prior to completion of cause of			
	sician cartific irector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	26. Place of Death (Check Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Home 5					conly one) ☐ Residence 6 ☐ Other (Specify)			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	atlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of (Month, Day Yeer)					cribe how injury occurred			
	tal or Attending I s after death. at Director: After ed in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined							lural Route Number,		
		edicai		ysician: To the best of my kno finer: On the basis of examina and manner stated.								
)	To the within 2 To the comple	Me	29b. Signature and Ottle of certifier	anna	M	29c. License	201	080	d. Date signed (Mon	th, Dey, Year)		
_	(3)		30-Name and address of person who	MD 14300	Gal	Print) lant Fox	clane;	Suite 2	22 Bon	rie md.		
	St Regist	ate rar	31. Date tiled (Month, Day, Year)  APR 0 6 2004	32. Registrar's Signa	ature	R.						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 3, **Physician** · Carolyn 2004 Basilio Virginia 4:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington hospital Ft. Washington Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Date of Birth 1 □ M 2013 F 85 Months Days Hours 0570271918 Maryland 218-30-3234 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28e-f ahow ?7 is marked other than "natural", or items 23s or 28e-f shov treumatic avent, the Medical Examiner must be notified at 1 Yes XXNo Director Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6612 Dublin Drive 20745 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any injury or other treumatic event, the Medical Example and pages. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married XX Married 1 ☐ Yes 2 Ho Specify: Completed by White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 in Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Irving Sherman Diven Jr. Florence Patchett 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crisanto R. Basilio / Husband 6612 Dublin Drive Oxon Hill, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 14☐Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Cemetery 05/06/2004 Arlington, Virginia 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licenses 22. Name and Address of Facility. George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland cles 20745 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALZHEIMER'S END STAGE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dive to for as a nonsequence of Examiner The law requires that the death certificate be executed the burial-transit attending physicien and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 東ত known Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 🗶 🛱 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 phopatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ 💢 o 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospitel of within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier cai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.P

32. Registrar's Signature

DEIDRAL. VARNER,

APR 0 5 2004

31. Date filed (Month, Day, Year)

D0033512

11701 Livingston Rd# 203; FT. WASHINGTON, MO 20744

So the position of the past 12 months?  1   Yes   2   No				1 - For State Registrar	of Marylan		artment of l		Mental Hygic	ene 1. No. 201	N. 126	0.0
## Contract   Contract		Physici	an	Decedent's Name (First, Middle, Last)					Month	Day Y	ear 3. Firma of Dec	都人
Seed Seedy National Court    County   C										2004		ам 
Social Security Number   Social Security Num	-	Examin	er	, ,					1	,		
216-58-9265   Margin   100 County   100 Co	1 。		23			last birthday)			8 Date of Birth			oreign
Use Part Section of December   100 County				4 C) 14 A C) C					(Month, Day, )	'ear)	Country)	
College (1-4of 5-)   Administrative Assistant   Federal Government   1   1   1   1   1   1   1   1   1		D					1		Aug. 17	1920	- Tennsy I vani	La
College (1-4of 5-)   Administrative Assistant   Federal Government   1   1   1   1   1   1   1   1   1		anylar show	<u>_</u>	10a. State 10b. County	10c. Cit	y, Town or Lo	cation					
College (1-4of 5-)   Administrative Assistant   Federal Government   1   1   1   1   1   1   1   1   1		Ba-f	ecto		Po	tomac	1	_	1			X1140
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College (1-4of 5-)   Administrative Assistant   Federal Government   1   1   1   1   1   1   1   1   1		eath	eral			.S. 13. V			pecify Yes or No-			
College (1-4of 5-)   Administrative Assistant   Federal Government   1   1   1   1   1   1   1   1   1	0	r Ren	Fun	Armed I  1 □ Never Married 2 🔀 Married 1 □ Yes	Forces? s 2⊠No				Rican, etc.)	Black,	White, etc.	
College (1-4of 5-)   Administrative Assistant   Federal Government   1   1   1   1   1   1   1   1   1	2	rel', o		3 Widowed 4 Divorced If Yes, 0	Give Dates:		1∐Yes 2ENo	Specify:		Specify:	White	
Compared to the control of the con	ر ا	72 h	etec		d)	16a. Dece	dent's Usual Occu	pation during most of work	king 16	b. Kind of Busin	ness/Industry	
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Compared to the control of the con	N	filed v Hygie ther t				Admir	istrativ				Government	
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Compared to the control of the con	2	shoul nd Me mart	F			19b. Mailir	ng Address (Stree			City or Town, Sta	ate, Zip Code)	
Compared to the control of the con		alth a alth a 27 is		William C. Burke/ Hus	band	8404	Pittsfi	eld Court	, Potomac	, MD 20	0854	
Compared to the control of the con	ž.	of He item			20b. P	lace of Dispo	sition (Name of		Date 20			
Compared to the control of the con	Ĕ	Page nent ant: II			n State   Ga1	Ceme	tery	Apr		ilver Sı	oring, MD	
Compared to the control of the con	<u>8</u>	armit. sportr nports ny nji		21. Signature of Funeral Service Licensee		22 F	Name and Addr	ess of Facility			100	
Acute Pneumonia  Internal Between Immediate Cause (Final Immediate C		\$0 5 5 B		J. Ken Stelle		50	00 Unive	rsity Blv	d. W., Si	lver Sp:	ring, MD 20	901
FFEMALE:   23d. Date of delivery   23d. Date of deli	8760,	Examiner  hysician and he burial-transit	ical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	o (or as a conseq ce Dement o (or as a conseq	uence of): t <b>ia</b> uence of):					4 Years	
1   Yes   2\frac{120}{2000000000000000000000000000000000	O. Box 6	death certific e attending p id for use as	ysiclan/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	birth 2 ☐ Feta gnant at time of d	Ideath 3		у				r
25. Was case referred to medical examiner?    Comparison of the completion of cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of performance of the cause of	1	uires that signed b d be deta	þ	Part II. Other significant conditions contributing to	death but not res	ulting in the u	nderlying cause gr	ven in Part I.				
Second   S	Ö	w req	lete						24a Wasan	24h War	re autonsy findings avai	ilable
The state of the s	Ĕ	he la e has age 2	dwc						autopsy performe	d? prio	r to completion of cause th?	e of
The state of the s	E	en: T tificat tor, pa	a)	25. Was case referred to medical				26 Place of Deat		1 No 1 L	Yes 2 No	
State   Stat		ysici is cer direc			Inpatient 2	ER/Outpatien	t 3 DOA Ot			e 6 Other	(Specify)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pasquale Santini M.D. 5530 Wisconis Avenue, Suite 1400, Chevy Chase, MD 20815  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	0	ng Ph		/440	e of Injury onth, Day Year)		28c. Inju Wo					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pasquale Santini M.D. 5530 Wisconis Avenue, Suite 1400, Chevy Chase, MD 20815  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	0	endii eath. or: Al	catle	2 Accident investigation								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pasquale Santini M.D. 5530 Wisconis Avenue, Suite 1400, Chevy Chase, MD 20815  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	Ĭ	r Att ter de irect n by t	rtific	determined 286. Plai			eet, factory, office				or Rural Route Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pasquale Santini M.D. 5530 Wisconis Avenue, Suite 1400, Chevy Chase, MD 20815  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		urs al		On Continue AVI Continue Division In Continue								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pasquale Santini M.D. 5530 Wisconis Avenue, Suite 1400, Chevy Chase, MD 20815  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		24 ho 24 ho 5 Fund etely f	dica	(Check only 2 Medical Examiner: On the	basis of examina	wieage, aeath tion and/or inv	estigation, in my	me, date and place, opinion, death occur	and due to the caustred at the time, date	se(s) and manne and place, and	er as stated. I due to the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pasquale Santini M.D. 5530 Wisconis Avenue, Suite 1400, Chevy Chase, MD 20815  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		omple					29c. Licen	se number	29d	. Date signed (A	Month, Day, Year)	
30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print)  Pasquale Santini M.D. 5530 Wisconis Avenue, Suite 1400, Chevy Chase, MD 20815  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature				· Con			Da	053711		4/5/04	1	
Ctate 31. Date filed (Month, Day, Year) 32. Registrar's Signature		10		30. Name and address of person who completed ca	use of death (Item	23a) (Type,	-					
Ctate 31. Date filed (Month, Day, Year) 32. Registrar's Signature	_	100		Pasquale Santini M.D.	5530 Wi	sconis	Avenue.	Suite 14	00. Chevy	Chase.	MD 20815	
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Physic		1- FOMEND#23a(c)perMD4 state Registra AMEND#19 aperf  1. Decedent's Name (First, Middle, Las Mary Estelle Be	1)				2. Date of Death Month	Day Yea	
/Med Exam		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of De	1:20 P.M
		Casey House			Rockv			Montgor	
Funera Director		5. Social Security Number 6. Se 070-30-7724 10 Usual Residence of Decedent	x 7. Age (In)	Yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 26,	<sup>y</sup> ear) 1903 Per	Birthplace (State or Foreign Country) nnsylvania
iryland show		10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
the Ma	Director	Maryland Montgome	ery	Rockvill					1 X Yes 2 □ No
death with the Maryland ms 23e or 28e-f show	ai Dir	4 Monroe Street #	603		10f. Zip Code 20	850		g. Citizen of What of United St	•
or Ite	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wi Specify: [A	
72 hours "netural",		15. Decedent's Edu (Specify only highest grad	ication fe completed)	(Give	lent's Usual Occup	during most of work	ina 1	6b. Kind of Busines	s/Industry
within iene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	life. L	oo NOT use retired acher	j)	9	Educati	on.
is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene, tiem 27 is marked other than "netur other traumatic event, the Medical	To Be C	17. Father's Name (First, Middle, Last)  A. Per Lee D. Bus		ie	actiei		e (First, Middle, M • McElro		
od 2 sho Ith and 27 is mu traum		19a. Informant's Name/Relationship (I) Ruth Ann Hannessia	(pe, Print) n m/Daughter			and Number or Run Avenue,		City or Town, State,	_
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	201	. Place of Dispo	sition (Name of	1	Date 3	Oc. Location - City of	or Town, State
it. Pag riment rtant: I		`4 Dopation 5 ☐ Other (Specify)	Me	edical C	enter	sity Marc	h 28 04 — —	Washingt	on,D.C.
Departiment Departiment Departiment Departiment Department	21. Signatur of Funeral Service Licens	Cerla	_   22 C	Name and Address	ortuary	Services	Inc. D.C. 200		
Pnysician		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the done cause on each line.  Acute Rena	eath. Do not ente	er the mode of dyin	g, such as cardiac o	nington, or respiratory arres	D.C. 200 it,	Approximate Interval Between Onset and Death 1 Month
/Medical Examiner	П	resulting in death)	Due to (or as a cons Chronic Re		luro				
	ner	Sequentially list conditions, if any seading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or es a cons		rure				1 Year
cate be executed ohysician and the burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	End Stag  Due to (or as a cons		l Diseas	se			>1 year
flicate   g physi	edicai		d						
requires that the death certific leen signed by the attending pi hould be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of prec 1 Live birth 2 For 4 Pregnant at time o 9 Unknown	etal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
res that igned b be deta	by PI	Part II. Other significant conditions cor			derlying cause give	on in Part I.	23e. Did toba	cco use contribute t	to the cause of death?
v requir been si should I	eted	Gastro	intestinal B	Teeding			1 ☐ Yes	2 <b>X</b> No 3 □ P	robably 4 Unknown
The lar ate has page 2	e Completed	05 W					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Physician: this certific al director,	0 8	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital: 1  Inpatient 2	☐ ER/Outpatient	3□ DOA Othe	26. Place of Death		ne 6 (StOther /Soc	ecify) Hospice
Jing Ph After th funeral	ation: T	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how		nospice
al or Attend after death Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre cify)	et, factory, office	2	28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
2 6 0	edical	29a. Certifier (Check only one)  1 XCertifying Physical Control (Check only one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and du	s stated. e to the cause(s)
ne Hospita n 24 hours ne Funera detely fille	673							D-1	
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Me	29b. Signature and little of certifier			29c. License		29d	Date signed (Mont	th, Day, Year)
To the Hospita within 24 hours To the Funera completely fille	Σ	29b. Signature and little of cartifier  30. Name and address of person who co	En		DØG	64121	3 290	3/29/	Day, Year)

			1 - For Registrar	State of Ma	arylan		artmen ertificat				-	giene Reg. No	200		1261	ΩΙ.
			Decedent's Name (First, Middle, Last	)				-			2. Date of De		00		3. Time of Dec	ath
	Physici /Medic		Rae Lee Benson								April	Da			7:20	Ам
	Examin		4e. Fecility Name (If not institution, give	street and number)			4b. City,	Town, or	Location	of Death		4c	. County of D			
			Shady Grove Adven	tist Hosp:	ital		Rock	vill	e				ontgom	ery		
	Funeral		5. Social Security Number 6. Se	7. Age	e (In yrs. i 85	last birthday Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	B. Date of Bir (Month, Da ugust 8	h y, Year)	9. 6	Country	ce (State or Fo	oreign
	Director		220-05-4030 Usual Residence of Decedent	- X		115.				A	ugust 8	, 191	.8 Ma	ryla	and	
	land ow		10a. State 10b. County		10c. City	, Town or L	ocation				<del></del>			100	I. Inside City L	imits
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	r 288	irec	10e. Street and Number				10f. Zip					10g. Cit	izen of What	Country	y?	
	th wit	aiD	19310 Club House H	Road Apt.#	204		20	886				Unit	ed Sta	tes		
	ams ams	Iner	11. Marital Status	12. Was Decedent E Armed Forces?	er in U.	S. 13.	Was Deced	lent of Hi	spanic Ori	igin? (Spec	ify Yes or No ican, etc.)	- 1	14. Race - Ar Black, W			
36	s afte	y FL	1 Never Married 2 Married	1 ⊟ Yes 2 📉 N If Yes, Give	lo		1 🗆 Yes		Specity:		, , , , ,					
21215-0036	hour tural	od be	3 XWidowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:		162 Door	edent's Usua	1.000000	tion			101 16	Specify: Wh			
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77	with jene. r than	шо	Elementary/Secondary (0-12)	College (1-4or 5	+)	Rece	ption	ist				Be1	l Tele	phor	1e	
פַ	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene. All Hygiene. Other than "natural", or Itams 23a or 28a-f show other than "natural", or Itams 23a or 28a-f show event, I're Madical Examira	3e C	17. Father's Name (First, Middle, Last)					-	18. Mothe	er's Name (	First, Middle,	Maiden	Sumame)			
/ai	uld b Venta vrked rife e	To E	Ludwell Lee						Go1d	lie Am	anda C	ator	ı			
Maryland	and l		19a. Informant's Name/Relationship (T)	pe, Print)									r Town, State			
Σ.	and sealth m 27		Warner Richard Ber	son/Son					ice S	treet	, Fred	eric	k, MD.	21	704	
altimore,	Fite Mark		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	20b. PI	lace of Displantery cre mac Un	osition (Nan	ne of ther place	Act A	April		20c. Lo	cation - City	or Towr	n, State	
ij	tmen tant:		*4 ☐ Donation 5 ☐ Other (Specify)		TOLO	Church	Cemete	ery		2004	- 1		omac, 1			
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene is the Marylan I is marked other than "natural", or I tams 23a or 28a-f show any injury or other traumatic event. The Madical Examinar must be notified at once.		21. Signature of Funeral Service Licens	Ž	M013	353 R	<sup>2. Name</sup> an ockvi ockvi	d Addres Lle, lle,	inc. Inc. Mary	yRobe; 300 1and	rt A. West M 20850-	Pump ontg 280	hrey F comery	une Ave	ral Hor nue	ne/
R	≅į. <sup>€</sup>		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each lin	the death	. Do not en	ter the mod	e of dying	, such as	cardiac or	respiratory ar	rest,		A	pproximate iterval Between	
	Pnysician	i ji	Immediate Cause (Final disease or condition	Int	rac	erebi	ral	Her	nor	rhad	2			,	nset and Deat へにからい	
a	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ience of):	, .			0	1 0			_		
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	pe tist	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,		/-								1		
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8760,	icate be executed physician and s the burial-transit	dicai Examiner			·	,										
687	ficate g phy: as the	edic												1		
Вох	The law requires that the death certificate has been signed by the attending spage 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of			7						23d. Date of d	leliverv		
	death	icia	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t			∃Ectopic pre ∃ Other (spe						Month	Da	y Year	
P. 0.	at the by th stache	hys	9 🗆 Unknown	9□ Unknown												
o,			Part II. Other significant conditions con	tributing to death bu	t not resu	lting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco u	se contribute	to the o	cause of death	?
ord	w requir	ted									1 🗆 Y	es 2ļ	X(No 3□1	Probabi	y 4 ⊟Unkn	own
Records,	has be	Completed									24a. Was a		24b. Were a	autopsy	findings avail etion of cause	able
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Vita	ysician: Th	Be	25. Was case referred to medical examiner?	1						of Death (	Check only or	10)				
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uo	ding After funer	tion	1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time o Injury	т 21 М	Bc. Injury Work	at ? es 2 □ N		d. Describe h	ow injury	occurred			
Division of Vital	Attending ir death. ector: After by the fune	fica	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	rv - At hor	me farm sti			95 Z [] [		Location /S	troot and	d Number or 6	Dural D	oute Number,	
2	after Dire	Certification:	4 Homicide determined	building, etc.	(Specify)	)	oot, ractory	Onice		201	City or Tow	n, State)	I Various OF F	nuran m	bule rvumber,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Physical Check only one)	ier: On the basis of	examınatı	vledge, deat on and/or in	h occurred a	it the time	e, date and inion, deat	d place, and th occurred	d due to the c	ause(s) ate and	and manner a place, and du	as state	d. e cause(s)	
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	- 3 + ŏ			House MD					987	/			ù 5,			
	10	1	30. Name and address of person who co		ath (Item	23a) (Tyne		0 0	, (	,		rpic	)	0.0	/	
			Cristin Parker How					nter-	Drive	e Roc	KVILL	e, N	0 20	850	S C	
	Sta Registra		31. Date filed (Month, Day, Year)	22 D wietra	r's Signati		So	nka	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March  $2^{\text{Day}}_{4}$ 2004 ANNA CATHERINE BENTZEL 4:20 Αм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Nursing Home Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 99 Director Maryland May 1, 1904 214-09-4217 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examples 1000. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Rosemont Avenue Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Charles Francis Sharer Eva Catherine Willhide 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Williard (Nephew) 4 Clarke Avenue, Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Weller Cemetery 3/27/04 Thurmont, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ROBERT É CON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) the by signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ pe D1-7-421mens cate has been sig. page 2 should b Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending I Director: A 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) The pletery filled in by 4 Homicide within 24 hours a To the Funeral [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller, MD 4 Culwell Drive, Mt. Airy, Maryland 21771 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #31 HC per DVR 4-5-04 AL State of Maryland / Department of Health and Mental Hygiene 2004 12686 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4:45 AM = Mma /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Columbia onni ano towave toward 5. Social Security Number 278-01 - 38 If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday /8. Date of Birth (Month, Day, Year) Feb. 27, 1 Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min 1 M 2 F 93 Director 1909 Ohio Usual Residence of Decedent the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-fehov rel', or Items 23e or 28a-f ehov Extranser coust be notified at 1 ☐ Yes 2 X No Maryland Howard Columbia Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7418 Sweet Clover 21045 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No tf Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2XXXVo Specify. þ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Than Its Elementary/Secondary (0-12) College (1-4or 5+) 11 Clerical Worker Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ever Frederick John Merce Harriet Grude 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 other tra Ann C. Danner / daughter 7418 Sweet Clover Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April ate 3, permit. Pages 1
Department of H
Important: If Ite
eny injury or otf 1 ☐ Burial 2XXCremation 3 ☐ Removal from State W. Arundel Crematory 2004 5 Other (Specify) \* 4 ☐ Donation Odenton, Maryland 22. Name and Address of Facility
Going Home Cremation Service

Beverly L. Heckrotte, P.A. Clarksvill MD 210

Approximate Interval Between Onset and Death 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service MO125 MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician BUVG - ag x /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 NO Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient funeral dir Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 🗌 Yes 2 No 24 hours after death

• Funeral Director: / 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year, 30 Name and address of person who empleted cause of death (Item 23a) (Type, Print) MI 1055 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

				State	of Maryla		artment of I <i>tificate of</i>		nd Mental H	ygiene Reg. No. 2 (	101.	12607
	Physic	ian	1. Decedent's Name (First, Midd	le, Last)					2. Date of D	Day Day	Your	3. Time of Death
	/Medi		Lola Florence	Bittinger					March	30, 200	4 Year	8:00 A.M.
	Exami	ner	4a. Facility Name (If not institutio	n, give street and n	umber)		}	•	n, or Location of Dea	th 4c. Count	y of Death	
			Goodwill Menno					Grants		(	Garret	-
	Funeral Director		5. Social Security Number 219–34–6449	6. Sex 1 □ M <b>20</b> %F	7. Age ( <i>In yi</i>	s. last birthday) Yrs.	If Under 1 Year Months Days			Day, Year)	9. Birthplac Country Mary.	ce (State or Foreign () land
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. 0	City, Town or Lo	cation				104	f. Inside City Limits
	Maryl f ehc	5	MD Garr	ett			Grantsv:	ille			100	1 ☐ Yes 2 1 No
	288	Je C	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country	,0
	3a or	□	16010 Bittinge	r Road				21536	5	-	SA	
	death	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in		Vas Decedent of I	Hispanic Origin	n? (Specify Yes or N		ce - American	Indian.
Maryland 21215-0020	be filed within 72 hours after death with the Maryland ntal Hygiene. Id other then "netural", or items 23a or 28a-f ehow event, the Mcdical Expirition.	þ	1 ☐ Never Married 2¼☐ Mari	If Voc G	2ឰNo iive	11	Yes, specify Cub  ☐ Yes 21 No	an, Mexican, I	Puerto Rican, etc.)		ick, White, etc	ò.
9	72 ho	Completed	15. Deceden	t's Education		16a. Deced	ent's Usual Occup	oation		16b. Kind of B		
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7	filed within Hygiene. other then "	Ş	10		(, , , , , , , , , , , , , , , , , , ,		Homen	naker		Or	wn Home	2
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yla	should be ind Mental I	၉	Harry N. Broad	water				I	da V. Dur	st		
Nar	2 2 2 2		19a. Informant's Name/Relations						or Rural Route Numi			
	Health Health em 27 I		Jeanne E. Meye	rs/Daugnt				er Klag	ge Road, G	rantsvi.	rie, Mi	21536
Baltimore,			20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation	3 □Removal from		Place of Dispos cemetery, crem	atory or other pla	ce)	Date	20c. Location	- City or Town	, State
Ę	t. Pa rtmer rtent: njury		4 Donation 5 Other (S		Gra	antsvill	e Cem.,	April	3, 2004	Grants	ville,	MD
Ba	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funefal Service	) Rum	a				Newman Fu Box 275,			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	ath. Do not ente	r the mode of dyir	ng, such as ca	rdiac or respiratory	arrest,	Ar	pproximate
i	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		hero so	clerchic	Caroli		ular di		Or	terval Between inset and Death
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	tificate be executed ig physician and as the burial-transit	Examiner	Sequentially list conditions,	b	Due to	or as a consequ	ence of):					
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Вох	atten for u	ian										
P.O.	the de	Physician/M	Part II. Other significent conditio	ns contributing to d	eath but not re	sulting in the und	derlying cause giv	en in Part I.	23b. Did	tobecco use co	ntribute to the	e ceuse of death?
σ.	es that the death certifi igned by the attending be detached for use as	ᅕ	Congestive	Hear	+ +	ailure			1 🗆	Yes 2□ No	3 Probabl	ly 4 💢 Unknown
Division of Vital Records,	uires n sign	od by	· ·						24a Was	an autopsy	24b. Were a	autopsy findings
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æ	he la e ha: age 2	E I								v	of deat	
ta	an: T	BeC	25. Was case referred to medical	- 1				26 Blace of	Death (Check only		1 ⊔ Ye	es 2 No
$\geq$	ysicia s cer direc	TOB	examiner? 1 ☐ Yes 2 ZÃNo	Hospital:	Inpatient 2	BR/Outpatient	3□ DOA Oth		ng Home 5 ☐ Resi		or (Consitu)	
0	g Ph er thi		27. Manner of Death	28a. Date		28b. Time of	28c. Injun Worl	at at		how injury occurr		
<u>.</u>	ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investig		III, Day 16ai)	Injury		Yes 2 □ No				
<u>\<u>\frac{1}{2}</u></u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place	of Injury - At h	nome, farm, stree	et, factory, office		28f. Location (	Street and Numb	er or Rural Ro	ute Number,
	talo rs aff									,		
	Hospi 4 hou Funer ely fil	edical		Physicien: To the	best of my knoasis of examina	owledge, death o	occurred at the tim	ne, date and pl	lace, and due to the occurred at the time,	cause(s) and ma	nner as stated	1.
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Med	0.107	and man	ner stated.							
	7 wit		29b. Signature and title of certifier	00	44.5		29c. License			29d. Date signed		- '
			Wonsack	/	MD			5532	5	Mar	in 30,	2004.
	3		30. Name and address of person v	who completed caus	se of death (Ite	m 23a) (Type, Pi	rint)		- /1	MW at	1-0-	
	0		31. Date filed (Month, Day, Year)	TIEN M	V 4	3 AUM	1erra	re f	rostburg	MV 21.	> 32	
	Sta Registr		APR	2 2004	Andrea .	M.	Cocath D					

Physici /Medio		1. De	cedent's Name (First, Middle,	State (							2. Date of De	ath	004	3. Time of Death
			James Bowser	, Jr.							April	06,	2004	20:39 M
Examir			acility Name (If not institution,		ımber)		4b. City,		Location o		0		inty of Death	eorge's
			200 Annapolis	. Sex	7 Age (In vrs	. last birthday)	If Under		If Under					place (State or Foreign
Funeral Director			77-48-7709	1 <b>X</b> M 2□ F		67 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da June 1	, 1936	Vi.	rginia
1111		Usua	Residence of Decedent		100 0	ity, Town or Lo	cation							10d. Inside City Limits
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tal Hygiene.  dother than "natural", or tems 23a or 28a-f show event, the Modical Evan car must be notified at	Director	10e.	C Street and Number				10f. Zip		ingto	JII		10g. Citizen	of What Cour	ntry?
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SE SE SE SE SE SE SE SE SE SE SE SE SE S	Funeral	ĺ	Marital Status	Armed F		U.S. 13.	Was Deced f Yes, spec	dent of Hi cify Cuba	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	)- 14. F	Race - Americ Black, White	etc.
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tygien her th		17 [	12th father's Name (First, Middle, La	ist)			Un	ion	Paint		(First, Middle,		rivate	
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perini. Tagos i and 2 should be within 12 mile popariment of leath and Mental Hygiene. Important: if item 27 is marked other than "natur any injury or other traumatic event, the Medical 2006s.	2	19a	Informant's Name/Relationshi				•				I Route Numbe			Code)
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rigation. The law requires that the obsain certains the certificate has been signed by the attending physial director, page 2 should be detached for use as the	Certification; To Be Completed by Physician/Medical	IF F 23b Part 25.	EMALE:  Was decedent pregnant in the past 12 months?  1	C. Due to d.  23c. If yes, or 1   Live 4   Preg 9   Unkr s contributing to or to be ed	utcome of pregulation	paquence of):  nancy tal death 3 [ death 5 [ d	other (sp	cause give	26. Place ar: 4 Nu at ? Yes 2   ne, date an	of Deathursing House No.	24a. Was autor period of the same super period of the same super s	obacco use of Yes 2 No an 24 no psy ormed? 2 No one) dence 6 No no injury oc Street and Num, State) cause(s) and date and place 29d. Date signal of the control of the signal of the cause	Month  contribute to the contr	Day Year  the cause of death?  pably 4 Unknown  posy findings available empletion of cause of  2 No  No  SCENE  al Route Number,  tated.  tated.  the cause(s)  Day, Year)

REPLACEMEN Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2 0°0 4 13°, Kenealy Reine Bushnell Apr. 0720 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North Arundel Hospital Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 1 ☐ M 2 🖫 F Yrs. n/a **Director** MD Feb. 17,2004 25 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits other treumatic event, the Mudical Examiner must be nutified at MD Anne Arundel Severna Park Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 44 Cedar Road 21146 USA or Items 23e Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐Yes 2 No 1 X Never Married 2 ☐ Married White 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygiene Importent: If item 27 is marked other the propriet in your or other treumatic event, ITEM 2005. n/a n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Christopher J. Bushnell Jennifer A. McGeady ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher J. Bushnell/Father 44 Cedar Road, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 27, 20a. Method of Disposition 20c. Location - City or Town, State Apr. 2, 2004 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Sudden Infant Death Syndrome (SIDS) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1X Yes 2 No 1 Yes 2□ No 25. Was case referred to medical 26. Place of Death Check only one) examiner? Hospital: Certification; To 1 **∑**Yes 2 □ No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending within 24 hours after death. To the Funerel Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

31. Date filed (Month, Day, Year) Registrar

S. R. Hogan,

32. Registrar's Signature

30. Name and address of person who colleged cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland

O.C.M.E.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** CHARLES EARL BRANDT APRIL 2004 07:40 a /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CUMBERI, AND

Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Onths Days Hours Min. June 22, 1924 MEMORIAL HOSPITAL ALLEGANY 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Virginia 1 M 2 ☐ F 219-14-5032 79 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits or 28e-f show event, the Medical Examiner trust be notified at 1 √Yes 2 No Director Mineral FT. Ashby 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? filed within 72 hours after death with 26719 USA PO BOX 686 or Itams 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Never Married 2 Married 1 TYPes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Peges 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "na sny injury or other traumatic event, Ita Maulto 2006. Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KAHTERINE SNYDER CHARLES E. BRANDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 24, PATASKALA, OHIO 43062 BETTY B. WELSHON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Ocemation 3 Removal from State
4 Donation 5 Other (Specify) SCARPELLI FUNERAL 04/13/04 CRESAPTOWN, MD Service Licensee 22. Name and Address of Facility SHAFFER FUNERAL HOME 21. Signature of uner 230 E. MAIN ST., ROMNEY, WV 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Gastrointestina /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Be Completed by Physician/Medical Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 ☐ No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifies 2004 APRIL / 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL HOSPITAL, CUMBERLAND, MD JAMES M. RAVER, MD 32. Registrar's Signature State Registrar

Jennifer Marie Campbell Unknown 04-094 04-02115 crn 1- For Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygien	e	
State of Maryland / Department of Health and Mental Hygien  Certificate of Death  Reg. N	2004	126
····g···		

91

Physician
/Medical
Examiner

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural, or Items 23a or 28a-f show any injury or other treumstic event, tra Medical Examinat must be notified at one.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and crimpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		Decedent's Name (First, Middle, Last)				2. Date of Deat			3. Time of Death
ciar dica		Jennifer Marie Campbell				Month March	27	Year 2004	1:02 A M
ine	r	4a. Facility Neme (If not institution, give street and number)	į	4b. City, Town, or		ath	4c. Cou	nty of Deeth	
		Route 65 at Herr Lane  5. Social Security Number 6. Sex 7. Age (In yrs. last	hirthdayl	Sna If Under 1 Year	rpsburg	S. 8 Date of Righ			ington place (State or Foreign
al or	- 1	214-02-3110 1 M 2X F 21	Yrs.	Months Days	Hours Mi		<sup>Year)</sup> 1982	Cou	Virginia
	1	10a. State 10b. County 10c. City, To	own or Lo	cation				1	10d. Inside City Limits
٤	5	Maryland Washington	Boon	sboro					1 ☐ Yes 2 No
1	2	10e. Street and Number		10f. Zip Code		1	0g. Citizen	of What Cou	ntry?
-	2	7509 McClellan Avenue		217	13			USA	
0		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? In, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		Race - Americ Black, White,	
Aby Emeral Director	L ACIT	XXNever Married 2 ☐ Married 1 ☐ Yes XXNo If Yes, Give Year or Dates:		1□Yes XXNo	Specify:		Spe	city:	White
100	מוני	15. Decedent's Education (Specify only highest grade completed)	(Give	tent's Usual Occup- kind of work done o	during most of w	rorking	16b. Kind of	Business/In	dustry
Completed	5	Elementary/Secondary (0-12) College (1-4or 5+)	ine. L	DO NOT use retired Cash i			F	ood Se	ervice
a	ם ם	17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle, M	Maiden Sum	name)	
F	2	David Lee Salgado				Ladawn Ca			
1	1	1.1.1				Rural Route Number,	•		
	-	Angela Campbell - Mother  20a. Method of Disposition 20b. Place		sition (Name of	704 Ra	nson, West		n - City or To	25438
		1 ☐ Burial 2 XCremation 3 ☐ Removal from State	itery, cren	natory or other plac	· 1				
	-	21 Ignatura Funeral Service Oceangee				.30,2004 S ome, P.A.	miths	burg,	Maryland
Side		1 hust 7 Sh				gue St. Wi	illiam	sport.	MD 21795
		23a. Part1. Enter the disease, or complications that caused the death. Eshock, or heart failure. List only one cause on each line.							Approximate Interval Between
n		Immediate Cause (Final disease or condition Multiple I	njuri	ies					Onset and Death
al f		resulting in death)  Due to (or as a consequent							
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- 00		dany loading to immediate Due to lor as a consequent cause. Enter Underlying Cause (Disease or injury	ce of it					- 4	
2	Ya	that initiated events c. resulting in death) Last Due to (or as a consequence	ce of):						
100	2	d d							
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A/uc	200	IF FEMALE: 23b. Was decedent pregnant 1	ath 3	Ectopic pregnancy				Date of delive	
		in the past 12 months?  1 Yes 2 No 9 Unknown  9 Unknown	5 □	Other (specify)				Month	Day Year
And Dhuelo	Ē	Part II. Other significant conditions contributing to death but not resulting	a in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use co	ontribute to th	ne cause of death?
1	2		•	, , , , , , , , , , , , , , , , , , , ,			s 2 No		pably 4 Unknown
100	completed					24a. Was ar	24	b Were auto	psy findings available
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0		25. Was case referred to medical			_26. Place of D	eath (Check only only	! 🗆 No   e)	1 🗆 Yes	2/X No
0		examiner?  1 X Yes 2 No  Hospital: 1 Inpatient 2 ER/	Outpatien	t 3 DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Reside	nce 6XX	other (Specific	at scene
		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28i (Month, Day Year)	b. Time of Injury	28c. Injun Worl	y at k?	28d. Describe ho OCCUPANT	w injupy occ	ofor	
1	, a	2 X Accident investigation 3-27-04 1:	2:50/	<b>√</b> M 1□	Yes 2 □ No	vehicle	eject	ed	
1914		4 Homicide determined building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (Sti City or Town	eet and Nut State)R	mber or Rura	Herr Lane
3	2	Street  29a. Certifier 1 Certifying Physician: To the best of my knowler	dae deeth	and word at the time	no, data and pla	Sharpsbu		7.	
100	edical cermication.	29a. Certifier (Check only one)  1 □ Certifying Physician: To the best of my knowler (2 ☒ Medical Exeminer: On the basis of examination and manner stated	and/or inv	vestigation, in my o	pinion, death oc	curred at the time, da	ite and plac	e, and due to	the cause(s)
1	3	29b. Signature and title of certifier	00	29c. License	e number	29	d. Date sig	ned (Month,	Day, Year)
		Ham Gronice -18	Vol		C.M.E.		Marc	h 27,2	2004
		30. Hame and address of person who completed cause of death (nem 23	Type,		nn Stra	et Baltimo	re Ma	ryland	21201
State		31. Date filed (Month Day Year) a 32. Registrar's Signature	11774	- III FE	iii 311 e	er palling	, e, Ma	yranc	21201
stra	0.0	MAR 3 1 2004 Jane 5		rede					
1/200	1		1-						

Registrar

			1 = For State Registrar	State of Man	yland / D		Health a	and Mental F		000	h 12602
	Physici /Medic Examir	al	4a. Fecility Name (If not institution, give s	ay Cra, trobi and number; unto 1851	mer o <sub>rtal</sub>	4b. City, Town	n, or Location of	2. Date of Month Morr	ch Z	Year 1,200 County of De	04 03 18 M
is.	Funeral Director		5. Social Security Number 6. Sex 214-28-0078	7. Age (I	n yrs. last birth 92 Y	Months Da		Min. 8. Date of (Month, Jan.	Birth Day, Year) 22,19	12 9. Bi	irthplace (State or Foreign Country) aryland
	e Maryland Ba-f ehow	ctor	10a. State 10b. County  Maryland Washin		Oc. City, Town	or Location Hagersto	wn				10d. Inside City Limits 1 X Yes 2 No
	3a or 2	at Dire	10e. Street and Number Ravenwood Assisted	Living		10f. Zip Cod	2174	0	_	izen of What C SA	Country?
980	filed within 72 hours after death with the Maryland Hygliene. ther than "natural", or flems 23s or 28s-f ehow ther than "natural", or flems 23s or 28s-f ehow int, the Medical Examinat he notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of If Yes, specify C		gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Arr Black, Wh Specify:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 le marked other than "natur may riqury or other traumatic event, the Medical DDGs.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)		Decedent's Usual Oc Give kind of work do life. DO NOT use rei housewife	cupation ne during most iired)	af working	16b. K	her ow	s/Industry 7n home
Maryland 2	S should be filed within and Mental Hygiene. Is marked other than aumatic event, the Man	To Be C	17. Father's Name (First, Middle, Last) Samuel H. Burke				C1a	r's Name <i>(First, Mid</i> ra L. Met	calfe	,	·
Mar	nd 2 sho lith and I 27 le mu r trauma		19a. Informant's Name/Relationship (Type Richard C. Cramer			Mailing Address (Str. P. O. Box					
Baltimore,	Pages 1 and 3 nent of Health ant: if Item 27 ury or other tr		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Ro 1 4 ☐ Donation 5 ☐ Other (Specify)		cemetery	Disposition (Name of crematory or other aven Ceme	tery	Date 3/24/04	На	_	m, Maryland
Balt	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service License	Mun	us S	A		MINNICH Blvd., Ha			
8	Physician /Medical Examiner		23a. Part 1. Enter the disease, or conclisions shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cation, that caused the cause on each line.  Due to (or as a c	sclero	teic Cou	tying, such as o		y arrest,		Approximate Interval Between Onset and Death IN S
8760,	eath certificate be executed attending physician and for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to incurred rate cause. Enter Underfund Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a c		*					
P.O. Box 68	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of particles of the second of the sec	Fetal death	3 ☐Ectopic pregna 5 ☐ Other (specify)				23d. Date of de Month	elivery Day Year
	equires that an signed b	Ď	Part II. Other significant conditions con	tributing to death but r	not resulting in	the underlying cause	given in Part I.			se contribute i	to the cause of death?
al Records,	sician: The law re certificate has be irector, page 2 sho	Completed						24a. W au pe 1 🗆 Yes	itopsy irformed?	prior to death?	utopsy findings available completion of cause of s 2 \( \square\$ No
Vital	Physician: this certificatal director, i	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	2 ARVOute	patient 3 DOA	O++	of Death (Check on rsing Home 5 🗆 Re		6 ∏Other (So	acifv)
Division of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this e mpletely filled in by the funeral di	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Y	eer) 28b. Tii	me of 28c. In	njury at Vork? Yes 2 N	28d. Describ			,
Divis	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After mpletely filled in by the funer		4 Homicide determined	building, etc. (	Specify)	π, street, factory, offi		City or	Town, State	)	tural Route Number,
	ne Hosp 24 hou ne Fune detely fi	Medical	29a. Certifier 1 Check only one) 1 Medical Examin	ician: To the best of n er: On the basis of ex and manner stated	amination and	death occurred at the for investigation, in m	time, date and y opinion, death	d place, and due to to h occurred at the time	he cause(s) ne, date and	and manner a place, and du	s stated. e to the cause(s)
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	5		30. Name and address of person who could AW 2 PAN.	mpleted cause of deat	h (Item 23a) (T 368	ype, Print) Strad	- Hel	gentauce	- Pel	D 21	740
9	Sta		31. Date filed (Month, Day, Year)	32. Registrar's		Man de la	(	0			

			1 - For State Registrar	State of Marylan		artment of He tificate of D			iene <sub>g. No.</sub> 2 (	004	12693
	Physici		Decedent's Name (First, Middle, Last)     VIOLA CHAPMAN					2. Date of Dea Month APRIL 8	Day	Year 4	3. Time of Death 1:20A M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or I	Location of Dea		4c. County		1.2011
			Crescent City (	Center		Riverd			Princ	e Geo	orge's
1	Funeral Director		232-30-4022	7. Age (In yrs. M 2 X F 91	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min		Year) 1912	9. Birthp Cour Geor	* *
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Manyl 1 eho	tor	MD Prince Ge	eorge's I	Lanham						1√ Yes 2 No
	7 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of \	What Cour	itry?
	th with	ai D	7102 Lory Lane			207	06		U.S.	Α.	
356	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f ehow ent, the Medical Examinat must be rediffed at	by Funeral		12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 Ki No If Yes, Give Year or Dates:	-	Was Decedent of His f Yes, specify Cuban 1 □ Yes 2፟\( \) No	panic Origin? (S , Mexican, Pue Specify:	Specify Yes or No- nto Rican, etc.)	Blac	e - Americ ck, White, V: Blac	etc.
ş	2 hou	ted	15. Decedent's Edu (Specify only highest grad		16a. Deced	dent's Usual Occupat	tion tring most of wr	orkina	16b. Kind of B	usiness/Ind	dustry
7	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired)	ming most of we	, and			
7	filed with Hygien Sther the	S	6th 17. Father's Name (First, Middle, Last)		Hou	se Wife	18 Mother's Na	me (First, Middle, I		vate	
Maryland 21215-0036	d ta b	To Be	Dixie Thoma				Na	ncy West			
Mar	2 60 00 10		19a. Informant's Name/Relationship (Ty Barbara Ashton/Gra		1	ng Address <i>(Street ar</i> Lory Lan					Code)
Baltimore,	Pages 1 and 2 nent of Health out: If item 27 iry or other tru		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	20b. F	emetery, crer	sition (Name of matory or other place) w Cemetery			20c. Location -		
Baltin	permit. Pages 1 Department of H Importent: If its eny injury or otl once.		21. Signature of Funeral Service Licens		22	Name and Address	of Facility J	. B. Jenk	ins Fu	neral	Home
			23a. Part1. Enter the disease, or compl shock, or heart failure. List onty of Immediate Cause (Final	ne cause on each line.	h. Do not ent						Approximate Interval Between Onset and Death
	Physician  /Medical Examiner	r	disease or condition resulting in death)	Due to for as a consequence.  Due to for as a consequence.	uence of):	DISCASE					
8760,	certificate be executed triing physician and tse as the burial-transit	ai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	F = 100 - 1						
687	ificate g phys as the	edical		3							
O. Box	death e atter id for u	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	ildeath 3□	Ectopic pregnancy Other (specify)	<u>,</u>	,		te of delive inth	ry Day Year
ds, P.	law requires that the de as been signed by the a 2 should be detached	d by Physi	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause giver	n in Part I.				e cause of death?
Records,	ie law require has been sig ge 2 should b	Completed						24a. Was a	y I	prior to cor	osy findings available inpletion of cause of
	Th ate pag	Con						perform 1 Yes	No No	death? 1 🗌 Yes	2 <b>K</b> No
Vital	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other		ath (Check only on			
	ng Ph ifter th ineral	lon: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 Nursing	Home 5 Reside			")
Division of		ertification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special			83 2 1110	28f. Location (St City or Town	reet and Numb s, State)	er or Rura	l Route Number,
_	To the Hospitel or within 24 hours afte To the Funeral Dii completely filled in	Medical C		sician: To the best of my kno ner: On the basis of examina and manner stated.							
	To the within 2 To the complet	Me	29b. Signature and title of certifier /			29c. License	number	2	9d. Date signe	d (Month, i	Day, Year)
)	->		· PILL 6			D250	79		April	9, 20	004
-	JAM J		30. Name and address of person who co			Print) e Place #	502 La:	nham, Mar	yland	2070	5
	Sta Regist		31. Date liled (Month, Day, Year) APR 0 9 2	32. Registrar's Signa	-	food			<del></del>		

	_	= State Registrar	Department of Health and N Certificate of Death	R	Reg. No.	
Physicia /Medic	ian cal -		CAMPBELL	1	Day Year 31, 2004	3. Time of Death 7:55 а м
Examin	ner	4a. Facility Name (If not institution, give street and number)  SOUTHERN MARYLAND HOSPITAL	4b. City, Town, or Location of Death CLINTON		4c. County of Death	EORGES
Funeral Director		5. Social Security Number  578-84-4046  Usual Residence of Decedent	Yrs.   If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.		1957 9. Birth	thplace (State or Foreign ountry) • C •
Maryland -f show		10a. State 10b. County 10c. City, Tow	wn or Location INGTON			10d. Inside City Limits
with the	۵	10e. Street and Number 3700 NINTH STREET, S. E. # 1126	10f. Zip Code 20032	1	10g. Citizen of What Cou	untry?
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic evant, I'm Marical Examitation and be netitived at	by Fur	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Pses 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White Specify: BL	e, etc.
within 72 hour ene. than "natural	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) PAINTER	rking	16b. Kind of Business/Ir	/Industry
uld be filed w Mental Hygier arked other th	To Be Coi	12th 17. Father's Name (First, Middle, Last) ANDREW CAMPBELL	18. Mother's Nam	me (First, Middle, M	Maiden Sumame)	Elib nez
1 and 2 should be Health and Mental Iam 27 is marked of other traumatic ev		MARY A. WALLACE (SISTER)	b. Mailing Address (Street and Number or Ru 8803 GREAT GORGE WAY	UPPE	ER MARLBORO,	, MD. 20772
t. Page rtment o rtant: tf		1 X Burial 2 □ Cremation 3 □ Removal from State RESU	ery, crematory or other place) URRECTION CEMETERY (	04-08-04		, MD.
permit. Departi Import any inj		21. Signature of Funeral Service Licensee  Wanda C. Bacon CC36	22. Name and Address of Facility W. 3447 14th STREET,	N.W. WA	ASHINGTON,	D.C. 20010
Physician /Medical Examiner	her	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to immediate cause. Enter Underlying	POLHONARY (		·	Approximate Interval Between Onset and Death
icate be physicia s the bur	edical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  c.  Due to (or as a consequence				
death certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ivery Day Year
		Part II. Other significant conditions contributing to death but not resulting in			obacco use contribute to to	the cause of death?
ystcian: The law requisions to the confident of the control of the	Completed by			24a. Was ar autopsy perform 1 Yes 2	prior to co death? 2- No 1 Yes	topsy findings available completion of cause of 2 □ No
ysician is certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Ou  27 Manner of Death	outpatient 3 DOA Other: 4 Nursing Ho		lence 6 ☐Other (Specif	ify)
to the Hospital or Arending Pn within 24 hours after death. To the Funarel Director. After th completely filled in by the funeral		1 Natural 5 Pending (Month, Day Year) in 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, fa	Injury Work? M 1 ☐ Yes 2 ☐ No	28f. Location (Str	now injury occurred  Street and Number or Rura on State)	ral Route Number,
a Hospital or A 24 hours after e Funarel Dira letely filled in b	edical Cert	29a. Certifier  1 Certifying Physicien: To the best of my knowledge (Check only  2 Medicel Exeminer: On the basis of examination and	e, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	City or Town, a, and due to the ca urred at the time, da	cause(s) and manner as s	stated. to the cause(s)
To tha F within 24 To the F complete		29b. Signature and title of certifier	29c. License number	29	29d. Date signed (Month,	n, Day, Year)
7		> Shuif Haun MD	050862		MARCH, 3	31,2004
0		30. Name and address of person who completed cause of death (Item 23a) (SHERIF HASSAN, M. D.	(Type, Print) 9831 GREENBELT LANHAM, MD. 2	Г RD. # 1 20706	103	
Sta Registra		31. Date filed (Month, Day, Year)  APR 0 7 2004  Medicar Signature	book			

	•	1 = For State Registrar	State of Mary	land / Depa		lealth and		giene	004 126
Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     Peter Paul Chich     Aa. Facility Name (If not institution, give s	street and number)	1.0		or Location of Deat		Day 4, 2004 4c. County	of Deeth
Funeral Director		3116 Gracefield Ro 5. Social Security Number 6. Sex 290–18–8854  Usual Residence of Decedent	7. Age (In	19 yrs. last birthday) 84 Yrs.	Silver If Under 1 Year Months Days	Spring If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da July 1	Montg th ay, Year) 1, 1919	omery  9. Birthplace (State or Fore Country)  Ohio
within 72 hours after death with the Maryland iene. then "natural, or Itama 23a or 28a-f show the Medical Examinar must be notified at	Direc	10a. State 10b. County  Maryland Montgomer  10e. Street and Number  3116 Gracefield Ro	cy		pring   10f. Zip Code   20	)904	Spanify Vas or No	10g. Citizen of V	10d. Inside City Lin 1 X Yes 2 □ What Country? e - American Indian,
thours after de stural, or itsm	ed by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 X Yes 2 No If Yes, Give Year or Dates: W cation	V II	Was Decedent of Hif Yes, specify Cubin 1 ☐ Yes 2 ☒ No dent's Usual Occup	Specify:		Specify	ck, White, etc.
filed within 72 Hygiene. other then "nal ent, it a Medic	Completed	(Specify only highest grade	College (1-4or 5+) 5+	(Give life. Chem	kind of work done DO NOT use retire	during most of wo d)	rking	Govern	
a d a	To Be C	17. Father's Name (First, Middle, Last) Andrew Chichilo				18. Mother's Name of Mary Va		, Maiden Suman	ne)
h a 7 Is		19a. Informant's Name/Relationship (Type Donald Chichilo –	Brother	216	ng Address <i>(Street</i> River Isl		enton,	Florida	34208
Pages 1 and ment of Healt ant: If item 2 ury or other		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☑ R  1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Wyuka Cei	matory or other pla metery	4/8	Date / 2004	Lincol	-
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service License	rea Ho	esel 4	739 Balti	more Ave	., Hyati	sville,	ome, P.A. MD 20781
Physician /Medical Examiner	, ,	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the le cause on each line.  Lymphoma  Due to (or as a co		ter the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death Years
e be executed sicien and e burial-transit	dical Examiner	Sequentially list conditions, any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a col						
by the attending phystached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			te of delivery nth Day Year
ate has been signed by the	ed by Pr	Part II. Other significant conditions con Hypertension, Liv	-	it resulting in the u	nderlying cause giv	ven in Part I.			ribute to the cause of death 3 ☐ Probably 4 🏾 Unkno
							24a. Was auto perfo 1 \( \text{Yes}	ormea?	Were autopsy findings avail- prior to completion of cause death? IYes2No
5 5	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient  28a. Date of Injury (Month, Day Yee	2 ER/Outpatier 28b. Time o	t 28c. Injui	ner: 4□Nursing F		one) dence 6 Oth how injury occur	
E Pitte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)	U-1412		City or To	wn, State)	er or Rural Route Number,
in 24 hours and the Funeral I	ledical	(Check only 2 Medical Examil	sician: To the best of my ner: On the basis of exa and manner stated.		vestigation, in my d	opinion, death occu		date and place,	and due to the cause(s)
within 2 To the	Σ	29b. Signature and title of certifier	<b>.</b>		29c. Licens D240			•	d (Month, Day, Year) 5, 2004
9) Wa	at c	30. Name and a sess of person who concluded Eugenio S. Machao  31. Date filed (Month, Day, Year)		110 Grac		oad, Silv	er Spri	ng, Mary	land 20904
Regist		APR 0 7 2004		K Goo	le				

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of N	Maryland / Dep Ce	partment of terrificate of	lealth and <i>Death</i>	Mental Hygio	ene 200	+ 12697
	Physici	an	1. Decedent's Name (First, Middle,		_			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Elizabeth Wa  4a. Facility Name (If not institution,	yne	Cox	4h City Town	or Location of Dea	April 4	4c. County of Deat	1:00 P M
	Examir	ier	9511 Monroe Str		• 7				, , , , ,	
	Funeral			6. Sex 7. A	Age (In yrs. last birthda	y) If Under 1 Year Months Days	rer Sprin If Under 24 Hrs Hours Min	8. Date of Birth	Montgome 9. Bird	thplace (State or Foreign
	Director		214-48-7958	1 □ M 2 🔀 F	86 Yrs.	Months Buys	110013	Oct.15,		nessee
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary a-feh	ctor	Maryland Montgo	nerv	Silver	Spring				1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
	s 23e		9511 Monroe Str				20910		USA	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Ie marked other than "natural", or Itams 23e or 28e-f show eumatic event, the Wedical Examinar must be norified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie  3 □ Widowed 4 ☑ Divorced	12. Was Deceder Armed Forces d 1 Tyes 2 Tild Yes, Give Year or Dates	XNo	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		specify Yes of No- to Rican, etc.)	14. Race - Ame Black, Whit Specify:	e, etc.
Maryland 21215-0036	72 hou		15. Decedent's			edent's Usual Occup		reking 16	Bb. Kind of Business/	nite Industry
2	ithin 7 nen "r Med	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	life	re kind of work done DO NOT use retire	d) most or wo	nking		
2	iled w Hygier ther th		12 17. Father's Name (First, Middle, La	neti	Teac	her	19 Mathada Na	me (First, Middle, Ma	Music	
and	0 = >	To Be								
ary	should be fand Mental I	F	Park H. Quille: 19a. Informant's Name/Relationshi		19b. Ma	ling Address (Street		. V. Becknoural Route Number, C		Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 should be Department of Health and Mente Important: If Item 27 Ie marked any Injury or other treumatic espoce.		Judith Baker  20a. Method of Disposition  1  Burial 2 □ Cremation 3		20b. Place of Disposemetery, cr	B Russell cosition (Name of ematory or other place a Cemetery	ce)	Date 20	c. Location - City or	
	artmer ortant Injury		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lie	at a 10 to make a		22 Name and Addre	APL .	8,2004 M		
B	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		( inchew	J. Cole	F	rancis J.	Collins	Funeral l	Home, Inc.	MD 20001
¥	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition	ne cause on each	ed the death. Do not e	nter the mode of dyir				Approximate Interval Between Onset and Death
L	/Medical Examiner		resulting in death)		is a consequence of):					
	ned neit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Congest	tive Heart is a consequence of):	Failure				
8760,	icate be executed physician and s the burial-transit	dical Exa	that initiated events resulting in death) Last	c. Due to (or a	is a consequence of):					
9	ntificat ng phy as th	Medi	IF FEMALE:							
O. Box	The faw requires that the death certificate be executed te has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No		2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,	-	23d. Date of deli Month	very Day Year
J.	res that tigned by	by Ph	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
rds	w require: been sig should b	ed b	Hypertension					1 ☐ Yes	2 <sub>X</sub> □No 3□Pro	obably 4 Unknown
Records,	The faw recate has been page 2 sho	Completed						24a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of
VItal	siclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					ath (Check only one)		
0	Phyei this c	L.	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 🗆 Inpat			4   Nursing F	lome 5 Residence		eify)
	iding Ith. Th.: After funer	tlon	1 Matural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of In (Month, D	jury 28b. Time Pay Year) Injury	Wor	yat k? Yes 2 □ No	28d. Describe how	injury occurred	
Division	To the Hospitel or Attending Physiclen: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification;	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of Ir	njury - At home, farm, s etc. <i>(Specify)</i>			28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical (	29a. Certifier 1X Certifying (Check only one)	Physician: To the best maniner: On the basis and manners	et of my knowledge, dea of examination and/or i stated.	th occurred at the tir nvestigation, in my o	ne, date and place pinion, death occu	a, and due to the caus urred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2.  To the complete	Σ	29b. Signature and little of certifier	10		29c. Licens	e number	29d	Date signed (Month	, Day, Year)
	5		Lapuros	a 4. Sa	in	D 13	548	Ap	ril 5, 20	04
			30. Name and address of person wi				W. C. C. C.	_		
	Sta	te	Rajindra K. Sar 31. Date filed (Month, Day, Year)	32. Regis	trar's Signature			Silver Spr	ing,Maryl	and 20901
	Registr	ar	APR 06 2	2004 Sen	we B	Spark	1			

			1 - For State Registrer	State of Many	land / Dep Ce	artmen e <i>rtificat</i>	nt of H	ealth a	and M	ental Hyg	giene Reg. No	2004	126	598
	Physici		1. Decedent's Name (First, Middle, Last,  Vernell Ophelia		,					2. Date of Dea Month April	Da	y Year	3. Time of E	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of		пріті		County of Death	10.25	
			Genesis Eldercare				Silv.	er Sr	ring			Montgome:	ry	
	Funeral Director		5. Social Security Number 6. Set	]M 2₩F	yrs. last birthday Yrs.	/) If Under Months	Days	Hours	Min.	(Month, Day	h v, Year)	9. Birthpi Coun	lace (State or try)	
	ס		579-42-5366 Usual Residence of Decedent		'0					Sep.9,1	1933	Wash:	ington,	,DC
	arylan show	_	10a. State 10b. County	10	c. City, Town or I	_ocation						10	Od. Inside City	
	the M.	Director	Maryland Montgome	ry	Silve	er Spr	ing				10- 04	i 100	1   Yes 2	- X NO
	as or		14510 Homecrest Ro	ad #3019		101. 210	2090	c			rog. Cit	izen of What Coun	try ?	
	death	Funeral		12. Was Decedent Eve Armed Forces?	r in U.S. 13	. Was Dece			gin? (Spe	cify Yes or No- Rican, etc.)		USA 14. Race - America		
36	s after		1 X Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes		Specify:	i, Puerto F	nican, etc.)		Black, White, e	∍tc.	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-f show dical Examinar must be coulded at	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a Dec	edent's Usua	al Occupa	ation			16h V	B1a		
715	within 72 ene. than "na	plet	(Specify only highest grad		(Giv	e kind of wo	rk done d	furing most	t of workin	g	10D. K	ind or business/ind	lustry	
2	filed with Hygiene other the	Completed	9		House	ekeepe	r			G	leor	getown Ur	niversi	ity
and	be file	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,				J
Maryland	2 should be to and Mental I is marked or raumatic eve	10	James Clark  19a. Informant's Name/Relationship (Ty	ne Printl	19h Mai	ling Address	(Street 2	and Numba	Mar		rey	r Town, State, Zip	Code	
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-f show gither traumatic event, the Medical Examination in the colling at		Vern E. Clark	Son								ing, MD 2		
Baltimore,	of Head		20a. Method of Disposition	2	Ob. Place of Disp	osition (Nar	ne of			ate		ocation - City or To		
Ē	Page ment		1 ⊠Burial 2 □ Cremation 3 □ F  '4 □ Donation 5 □ Other (Specify)		Harmony	Memor		.	or.8	2004	Lan	dover,Mar	vland	
Balt	permit. Pages Department of It Important: If ite any injury or of		21. Signature of Funeral Service Licens	90	Fi	22. Name an	d Addres	s of Facilit Colli	ns F	uneral	Home	e, Inc.		
	40244		23a. Part1. Enter the disease, or compl	cations that saused the	- 50	00 Uni	vers	ity B	lvd.	.W. Sil	ver	Spring.N	D 2090 Approximate	
H	Priysician		snock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.			or dy mig	g, 04011 40 1	ou. 0100 01	roophatory arr	631,		Interval Betwee Onset and De	een
	/Medical		disease or condition resulting in death)	Due to (or as a co						_				
g.	Examiner	L	Sequentially list conditions, if any, leading to immediate	General De	ebility									
	ted nsit	nine	if any, leading to immediate Cause (Disease or injury	Due to (or as a co										
Ć	execu in and ial-tra	Examine	that initiated events resulting in death) Last	Due to (or as a co		cers						-		
8760,	cate be executed physician and the burial-transit	dicai		1										
9	eath certific attending pl for use as t	/Med	IF FEMALE:	2a If you subsemp of a							-			
Вох	death certific e attending p id for use as	clan	in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	□Ectopic pr					1	23d. Date of deliver Month	y Day Ye	ar
O.	s that the death ned by the atter s detached for u	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown										
S, D	9 5 g	by	Part II. Other significant conditions cor	tributing to death but no	ot resulting in the	underlying c	ause give	n in Part I.		23e. Did tol		se contribute to the	e cause of dea	ath?
ord	w requir been si should	eted								1 🗆 Yı	es 2[	Vo 3 □ Proba	ibly 4 □Unl	known
Vital Records,	Physician: The law r this certificate has b aral director, page 2 s	Completed								24a. Was a autops perform	sy	24b. Were autop prior to com death?	sy findings av pletion of cau	allable ise of
ta		d)	25. Was case referred to medical					OC Disease	of Dooth		2 No		2□ No	
	ysicia is ceri direct	To B	examiner?	lospital:	2 ER/Outpatie	ent 3 DC	Other	1245				5 □Other (Specify)		
0 0	ng Ph (fter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time (	of 2	8c. Injury Work			8d. Describe h				
Division of	or Attending Physician: after death. Director: After this certific in by the funeral director.	cat	2 Accident investigation 3 Suicide 6 Could not be	an Blace of leister	A45	M		'es 2 □ N		Df. 1 41 (O				
<u>&gt;</u>	after after I Direct	Certification;	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	pecify)	reet, ractory	, office		20	City or Town	n, State)	d Number or Rural )	Houte Numbe	ır,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifying Physic (Check only one)	sician: To the best of moner: On the basis of exa	y knowledge, dea mination and/or in	th occurred nvestigation,	at the time , in my opi	e, date and inion, deat	d place, ar h occurred	nd due to the ca	ause(s) ate and	and manner as sta place, and due to	ted. the cause(s)	
	within 2 To the comple	M	29b. Signature and title of certifier	101		290	. License	number		2	9d. Date	e signed (Month, D	ay, Year)	
•	5		Daima	Inche	ma	D	5896	5		A	pri	1 5, 2004	4	
			30. Name and address of person who co				#10		1	1	0.0	0.5.0		
	Sta	te	Saima Khawaja, M.D 31. Date filed (Month, Day, Year)	32. Registrar's	ckville Signature	/			CKVIL	re, MD	20	852		
	* Registra	ar	APR 0 7 2004	Sener	B	papa	KS							

			Please	State of Ma					•	_	bie.	
			1 = For State Registra AMEND#7 perFH4		-	-	tificate of				004	12690
	47		Registrari (LIV)#/DELFF/4,  1. Decedent's Name (First, Middle, Li		0	0071	incate of	Death	2. Date of Deatl	g. No.		3. Time of Death
stq.	Physic		CHARLES R.		ΕY				APRIL	3 20	004	1:40 P M
	/Medi Examir		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, o	or Location of Death	1	4c. County	of Death	
Æ.			SHADY GROVE NURS				ROCKV			MON	TGOMER	
2.20	Funeral Director		578 26 5280	Sex 7. Age 1028 M 2 ☐ F	(In yrs. last bird	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 5	,1926	9. Birthpla Count Mary	ace (State or Foreign try) yland
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Loc	ation				10	Od. Inside City Limits
	the Mary 28a-f eh	Funeral Director	Md. Monto	gomery	Ga	ithe	ers burg		10	g. Citizen of 1	What Count	1 ☐ Yes 2 ☐No
	3a or	D	8910 Primula Dr	ive				882		-	ed Sta	-
	death ms 2;	era	11. Marital Status	12. Was Decedent 8	er in U.S.	13. W	1	dispanic Origin? (Si an, Mexican, Puerti	pecify Yes or No-	14. Rac	ce - America	an Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then *naturel; or items 23e or 28e-f ehow my injury or other traumatic event, the Medical Example rusal be nuitled at once.	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 1 N If Yes, Give Year or Dates:	WWII		Yes, specify Cub □Yes 2, No		o Hican, etc.)	Specif	ck, White, e <sup>(y:</sup>	white
Š 2	72 ho	Completed	15. Decedent's E (Specify only highest gi	ducation rade completed)	16a.	(Give k	ent's Usual Occup	during most of wor	kina	6b. Kind of B		•
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<u>a</u>	ld be ental ked o	To Be	Jacob Richard	d Carey				Levenia	Corde	lia <i>i</i>	Anders	son
ary	12 should be f h and Mental h 7 is marked of raumatic eve	-	19a. Informant's Name/Relationship					and Number or Ru				
Σ.	and 2 salth in 27 i		Russell A. Care	y / Son				Drive, 0				0882
Baltimore, Maryland	H iter	>	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 (	☐Removal from State	cemeter	ry, cremi	ition (Name of atory or other pla			Oc. Location		
E E	it. Pa rtmen rtant: njury		<ul> <li>4 □ Donation 5 □ Other (Spec</li> <li>21. Signature of Funeral Service Lice</li> </ul>		Gate	-	Heaven C				Sprii	ng, Md.
Ba	Depermine Dependent of the population of the pop		21. Signature di Funeral Service Lice	W. Ba	uller		Muriel H	SS of Facility Barber OX 5038,	Funeral	Home	M/I 21	N88 <b>2</b>
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death. Do r							Approximate Interval Between
	Physician		tmmediate Cause (Final	y one cause on each lin	STAG	F		HL DIS				Onset and Death
	/Medical		disease or condition resulting in death)	a	a consequence	of):	1/12/18	11- 1712	NA SE			1110
	Examiner		Sequentially list conditions.	b								
	pe jist	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence o	ur):						
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760,	te be executed ysicien and e burial-transit	<u>a</u>		d								
89	ntificat ng phy as th	Med	IC CENAL C									
Box 68	The law requires that the death certificate tie has been signed by the attending phys page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 ☐ Fetal death		Ectopic pregnanc	у			te of deliver	ry Day Year
0	the a	yslcl	1 Yes 2 No	4☐Pregnant at 9☐ Unknown	time of death	5 🗆	Other (specify) _		-			, , , , ,
P.O.	that the ded by detac	'Ph	Part II. Other significant conditions	contributing to death by	ut not resulting in	the und	derlying cause gr	ven in Part I.	23e. Did tob	acco use cont	tribute to the	e cause of death?
rds	quires n sign ald be	d by	DIABETES	MELLITI	15				1 ☐ Ye	s 2 🗆 No	3 Proba	ably 4 onknown
Vital Records,	av requi	Completed	HYPERTE	NSION					24a. Was an	24b.	Were autop	esy findings available appletion of cause of
		E	CONGEST	IVE HEA	RT F	AIL	UPE		autopsy perform	ed?	death?	2016
/ita	ysicien: The is certificate hadirector, page	Be (	25. Was case referred to medical examiner?						th (Check only one	)		
0	Physi this c al dire	2	1 ☐ Yes 2 ☑ No 27. Manner of Death		nt 2 ER/Ou		3 DOA		ome 5 Resider			)
no	ding Ph h. After th funeral	tlon	1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		rime of njury	28c. Inju Wo M 1	rk?  Yes 2 □ No	28d. Describe hor	w injury occuri	red 4	
Division of	or Attender fiter deat jirector: in by the	Certification;	2 Accident investigate 3 Suicide 6 Could not 4 Homicide determine	be 29a Blace of Inju	iry - At home, fa :. (Specify)	rm, stre		_	28f. Location (Str. City or Town,		er or Rural	Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: Atter this certifica		(Check only2   Medical Exa	Physician: To the best of sminer: On the basis of	examination and	, death d/or inve	occurred at the trestigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and ma	anner as sta and due to	ited. the cause(s)
	ithin 2 o the	Medical	29b. Signature and title of certifier	and manner sta	ted.		29c. Licens	se number	29	d. Date signe	d (Month, D	Day, Year)
			Jok La					28656		PRIL	032	2004
3	541		30. Name and address of person who	completed cause of de	eath (Item 23a) (	(Type, P				1	1	
			RAVI PASSI MO	1 2000	HATDY G	FRO	VE ROA	D#20	8 KOCK	VILLE	MD	20850
	St. Regist		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	4	poare		,			

State of Maryland / Department of Health and Mental Hygiene? 00

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			1 - State Registrar	,	Ce	rtificate of	Death	R. C. Carlon	eg. No.	L.	12/00
	7 6	*	1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat	h		3. Time of Death
١.	Physici		Doris Rene	Ciango				April 2	2. 2004	ear	10:20 ам
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Dea		4c. County of	Death	10.20
1 4		-	10318 Geranium	Avenue		Adelph	i		Prince	Geo	rge's
	*. Funeral		5. Social Security Number 6. Se	, , ,	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Your 9	. Birthpla	ace (State or Foreign
L	Director		5/8-24-3421	□M 2⊠F 79	Yrs.	IVIOITIIIS Days	Hours Mill	March 1		Kent	ucky
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	eation				10	4 1 - 14 - 05 - 11 - 12
	eho	ក								100	d. Inside City Limits 1 ☐ Yes 2 2 No
	the N	Director	Maryland Prince  10e. Street and Number	George's	Adelph:						
	with a or	ā	10318 Geranium A			10f. Zip Code 20783		1	0g. Citizen of Wha	it Countr	ry?
	leath	Funeral	11. Marital Status	12. Was Decedent Ever in U	IS 13 1		ispanic Origin? (	Specify Ves or No-	USA 14. Race -	Amorica	o Indian
	fter of	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of H f Yes, specify Cuba	an, Mexican, Pue	rto Rican, etc.)		White, et	
036	hours after death with the Maryland turel', or Items 23s or 28e-f ehow at Extentinest be moffited at	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2Å No	Specify:		Specify: W	hite	2
Maryland 21215-0036	d within 72 hours after death with the Marylan piene. r then "neturet", or Items 23a or 28e-f ehow It e Madical Exantret mat be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual Decup	ation		16b. Kind of Busin	ness/Indu	ıstry
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7	e filed within Il Hygiene. other then vent, It e Ma	Co	12		Offi	ce Manag			Typese	ttin	ng
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<u>Y</u> a	2 should be to and Mental his marked or reumetic eve	은	Oliver J. Sm:					Leach			
Nar	and and rism		19a. Informant's Name/Relationship (T	ype, Print)				ural Route Number,			Code)
	t and Health Im 27		Paul Ciango/ Son  20a. Method of Disposition	205		8 Geranit	ım Avenu	e, Adelph			
altimore,	M it of h		1 Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crer	natory or other plac			20c. Location - Cit		
Ħ	it. Pa rtmer rtent njury		* 4 □ Donation 5 □ Other (Specify,			shington		4/6/04	Adelpl	aí, l	Maryland
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other treumetic et once.		21. Signature of Funeral Service Licens	-Cole	F1 50	Name and Address ancis J. O Univer	ss of Facility Collins sity Blv	Funeral d. W., Si	Home Inc. lver Spr	ing	MD 20901
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	Physician		Immediate Cause (Final disease or condition	. Chronic Obs	tructi	ve Pulmor	arv Dis	ease		C	Onset and Death O Years
	/Medical		resulting in death)	Due to (or as a consec			, 515				0 lears
	Examiner		Sequentially list conditions.	b							
	p tis	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consec	quence of):					19	
	eriifcate be executed ling physician and e as the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a conseq	uanaa of):						
60,	be ey			Due to (or as a conseq	(uence or).						
68760,	physis the	Medical		d						-	
×	eath certificate be executed attending physician and for use as the burial-transit		IF FEMALE:	23c. If yes, outcome of pregna	ancv						
Bo	that the death cended by the attendi	Physician/	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	ıldeath 3⊑	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Di	
o.	the d y the iched	ıysı	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	out.	Cirior (specify)					
٦	The law requires that the tee has been signed by the bage 2 should be detachen	y Pt	Part II. Other significant conditions co	ntributing to death but not res	ulting in the ur	iderlying cause give	en in Part I.	23e. Did tob	acco use contribut	te to the	cause of death?
Records,	quires n sign	Completed by	Atherosclerosis					1 □ Yes	s 2□No 3□	] Probab	ily 4 ⊠Unknown
O <sub>O</sub>	w requir s been si should	lete						24a. Was an	24h Wer	e autons	y findings available
	The tay ate has page 2	шо						autopsy	prior deat	to comp h?	letion of cause of
Vital		a)	25. Was case referred to medical				26 Place of De-	1 ☐ Yes 2		Yes 2	∐ No
	S S E	o B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3□ DOA Othe		fome 5 ☑ Resider		Specify)	
o C	iding Phye th. : After this funeral di	i.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe hov		pochy	
Ö	Attending or death. ector: After by the fune	atlo	1 ⚠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Months, Buy Your)	Injury		res 2 🗆 No				
Division	or Attendater death Director: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (Stre City or Town,		r Rural R	loute Number,
	spitel or At ours after d serel Direct filled in by			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				J., J. 751,	oldio)		
	Mospite 24 hours Funerel etely filled	cal	(Check only 2 Medical Exami	sician: To the best of my kno iner: On the basis of examina	wledge, death	occurred at the time	e, date and place	, and due to the cau	use(s) and manne	r as state	ed.
	To the Hospitel or within 24 hours after to the Funerel Director completely filled in I	Medical		and manner stated.							
	To viit	e=	29b. Signature and little of certifier	1184.		29c. License	nump9ř	29	d. Date signed (M	onth, Da	y, Year)
•	5		- manuel	MASUL			1563	A	pril 5,	2004	
			30. Name and address of person who co				NE C.		·	001	
	Sta	to.	Charles M. Benner 31. Date filed (Month, Day, Year)	M.D. IU801 I		a Drive,	NE, S11	ver Sprin	g, MD 20	901	
	Sid Renistr		APR 0.6 200	14 General	4	lon st	/				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND #20bperFH4/14/04,BMW,McCo Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2004 Month **Physician** April 6, Norah Cahalan 9:00 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Potomac Montgomery Manor Care-Potomac If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖾 F Months Hours 213-44-4479 80 Director June 25, 1923 Ireland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hyglena. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any linute or other traumatic event, the Medical Examiner must be notified at ODGs. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 1 ☐ Yes 2X No Maryland Montgomery Potomac Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10714 Potomac Tennis Lane 20854 Ireland Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Caregiver 6 Children's Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Not Available Ellen Cahalan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert J. Cassidy/Nephew 1016 Junipero Serra Blvd., San Francisco, CA 94132 20b. Place of Disposition (Name of cemetery, crematory or other place) Unknown 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-14-2004 Dunboyne, Ireland 4 ☐ Donation 5 ☐ Other (Specify) Rooske Cemetery 22, Name and Address of Facility
Robert A. Pumphrey Funeral Home/ Chase. Inc. 21. Signature of Funeral Service Linenses Chase, M00198 |7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Demen **Examiner** Due to (or as a consequence of): Be Completed by Physician/Medical Examiner use as the burial-transit or Attending Physician: The law requiras that the daath certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probabty 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2/10 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No edical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred To the Funeral Director: After complately filled in by the funer Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

Registrar

State

1220 A Evert

32. Degistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Switha Bhogavile

APR 0 9 2004

31. Date filed (Month, Day, Year)

00054566

JOSPA Road Stait 230 JOCOSON \* DZ12 FG

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Maryland		rtificate of L			ı. No.	
泰			Decedent's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al	5 Cm.10 C	Carroll				March 2		9:08 A M
	Examin		4a. Facility Name (If not institution, give str		-		Location of Death		4c. County of Dea	
		$\Sigma_{>}$	Frederick Memori 5. Social Security Number 6. Sex	al Hospita 7. Age (In yrs. I		Freder	1 C K If Under 24 Hrs.	8. Date of Birth (Month, Day, )	Frederic 9. Bin	thplace (State or Foreign
	Funeral Director		579-34-3342 塚小	1 2□F 74	Yrs.	Months Days	Hours Min.	Oct. 11,	1929 V	lrginia
	death with the Maryland ms 23e or 28a-f show Imagi be notified at		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	a-fs	ctor	Maryland Frederic	k	Fred	erick				
	or 28	Dire	10e. Street and Number			10f. Zip Code			g. Citizen of What Co	•
	ath w	rai	109 North Market St	reet . Was Decedent Ever in U.:	C 13	2170			United St	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If team 27 is marked other than "natural", or items 23e or 28e-1 show amy injury or other traumatic event, it a Medical Examinat must be notified at any injury or other traumatic event, it a Medical Examinat must be notified at any injury.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Storocced	Armed Forces? 1 ⊠Yes 2 □ No 195	1-	Was Decedent of Hi It Yes, specify Cuba 1□ Yes 2⊠ No		Rican, etc.)	Black, White	e, etc.
2-003	"natura	Completed	15. Decedent's Educa (Specify only highest grade of	tion	16a Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing 16	6b. Kind of Business	Industry
7 7	within ane. than	дшс	Elementary/Secondary (0-12)	College (1-4or 5+)		ry Store			Retail	
<u> </u>	illed Hygi other	0	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Mi		
/land	uld be Menta rrked rtic ev	To B	Early Edward Carro	11				Bernice W		
Mary	od 2 should and Milh		19a. Informant's Name/Relationship (Types Nancy Bomango / Sis			ng Address <i>(Str</i> eet a . Market			City or Town, State, 21701	Zip Code)
more,	Pages 1 arent of Heam nt: If Item ry or othe		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Rei 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	-	osition (Name of matory or other place Mem. Gar	, marc	h 29.	oc. Location - City or	
Baltimo	permit. I Departm Importa any inju		21. Signature Funeral Service Licenses		Re	2. Name and Address thaven F	s of Facility uneral S	ervices,	Skkot Cod lerick, MD	y P.A.
W			23a Party Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death	n. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	Acute Renal F	ailure					Onset and Death
	Examiner				structure	Pulmonary Dis	seast			710 years
	uted	Examiner	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of the consequence of t	1	r (vaspecifi	ed			Unknown
60,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a consequent	A ' (A	consont				2days
68760,	ficate physis the	edical	d.		-104	7	0.00			N-1000
Box	The law requires that the death certific to has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3	□Ectopic pregnancy □ Other (specify) _	1		23d. Date of de Month	livery Day Year
s, P.O	es that th gned by be detach	by Phy	Part II. Other significant conditions cont	ributing to death but not res	ulting in the	underlying cause giv	en in Part I.			o the cause of death?
ord	w require been si									
Vital Records,	The law at the has by page 2 st	Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of s 2 No
ţ	ysician: Th	Be	25. Was case referred to medical examiner?			To.		th Check onl one		
<u>&gt;</u>	Y S	၉	1 ☐ Yes 2 🗹 No		ER/Outpatie	-	4   Nursing H	ome 5 Resider	nce 6 Other (Spe	ecify)
ono	fing After funer	ation:	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wor	yat k? Yes 2 □ No	Zad. Describe not	w injury occurred	
Division of	after des Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, tarm, s	treet, factory, office		28t. Location (Str. City or Town,	eet and Number or F State)	tural Route Number,
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely tilled in by the funeral	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, dea ation and/or i	ath occurred at the til nvestigation, in my o	me, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	Fo the	Me	29b. Signature and title of certifier			29c. Licens	0 . 2 2 7	29	d. Date signed (Mor	
-	- 1		> Stena M.1)	-		Do	055795		3-21-	.04
<i>[-</i>	)+1		30. Name and address of person who con	mpleted cause of death (Iter	A. 5 B	Print) The St	nut Ind	erick MC	21701	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	South				

				For State	State of M	1arylan						Mental H		20	0.1	10
		-		Registrar  1. Decedent's Name (First, Middle, Last)			Cei	rtificat	e or i	Deair	<i>i</i>	2. Date of	Reg.	No. 2 U	UU	3. Time of Death
-	71	Physici /Medio		Mary Rita Cezar								Month April		Day 2004	Year	9:45 P <sup>M</sup>
		Examir		4a. Facility Name (If not institution, give	street and number	r)		4b. City,	Town, o	r Location	of Death			4c. County o	f Death	
_	ķ.			Gilchrist Hospice				Tows						Baltim	ore	
		Funeral Director		210-14-8211	7. A	ige (In yrs. 80	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of (Month, Dec 1	Day, Ye	ar)	9. Birthp Coun [ary]	
Z		and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							11	0d. Inside City Limits
ndshibo		ith the Marylar or 28e-f show	tor	Maryland Howard		F11	icott (	7:+37								1 ☐ Yes 2 No
7.		r 286	rec	10e. Street and Number		1111.	ICOLL (	10f. Zip	Code				10g.	Citizen of Wh	nat Coun	try?
5		th with	Funeral Director	8700 Ridge Road #4	424			210	43				US.	A		
0		r dea	ner		12. Was Deceden Armed Forces	?		Was Dece If Yes, spe	dent of H	lispanic O an, Mexica	rigin? (Sp an, Puerto	ecify Yes or Rican, etc.)	No-	14. Race Black	- Americ White, o	
7	36	hours after death with the Maryland tural', or Items 23a or 28e-f show al Exartine Emust be notified at	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give			1 🗆 Yes	2 💢 No	Specify	<i>r</i> :			Specific		
4564	215-0036	tural	edt	15. Decedent's Edu	Year or Dates	-	16a. Deced	dent's Usu	al Occup	ation			16b	. Kind of Bus	Whit	
7	15	within 72 ene. than "na	plet	(Specify only highest grade Elementary/Secondary (0-12)		5.1	(Give	kind of wo DO NOT u	rk done d se retired	during mo.	st of work	king	1,00			2001
	212	d with giene er tha	E O	12	College (1-40)	3+)	Homen	naker					0	wn Hom	e	
5		al Hygi d other	Be Completed	17. Father's Name (First, Middle, Last)										len Sumame,	)	
3	yla	2 should be f and Mental b Is marked of reumatic eve	2	Bernard M. Thompso								Tully				
N	Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla. If Heath and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-1 show other treumatic event, the Medical Exartic elements to incitified.		19a. Informant's Name/Relationship (Ty				-						ty or Town, S.		
$\sim$		1 and Health em 27		Edward C. Cezar /	son	20b. F	lace of Dispo	sition (Nai	ne of	1				ryland Location - C		
7	nor	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from Stat	0	emetery, cren Arunde	,		· 1	•	1 <sup>11</sup> 7,		enton,	•	
	altimore			21. Signature of Funeral Service Ligens	<del>00</del>	1 ** •				-						
	~ m	permit. Departr Importe any inje		Beverly L. Hay	rutte	MO I	GC 1251 Be	oing l	Home	Crem	natio	n Serv	ice . C	P.O.	Box	784 MD 21029
				23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that cause	ed the deat								LGINSV	1110	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	lvn	(	Ance	S								Onset and Death
		/Medical		resulting in death)	Due to (or a	s a conseq	uence of):									
	в	Examiner	_	Sequentially list conditions,	o											
		ed	nine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to [or a	s a conseq	uence of								-1	
		cate be executed obysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a	s a conseq	uence of):								-	
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	9	ifficate g phys as the	ledic		·						= 57075					
	Вох	aath certific attending p for use as	by Physician/Me	23b. Was decedent pregnant	3c. If yes, outcom			Ectopic p	ennancy	,				23d. Date		'
		ne death the atte	sicia	in the past 12 months?	4☐Pregnant 9☐ Unknown			Other (sp					_	Month	h	Day Year
	P.O.	that the deed by the detached	Phy	9 Unknowh			Was to M					00 - D	44-5			6.4.110
	Division of Vital Records, P.O.	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as		Part II. Other significant conditions con	itributing to death	but not res	uiting in the ui	nderlying o	ause give	en in Part	I.		i			e cause of death?
	Ö	v requires been sign should be	Completed													
	Rec	ne law has ge 2 s	Idm									24a. W	as an topsy nformed	24b. We pride	ere autop or to com ath?	psy findings available appletion of cause of
	a	ician: The l certificate ha ector, page	ပ္	25. Was case referred to medical						00.81		1 Tes	2 🔀	No 1	Yes	2 🗆 No
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	o	ig Physiter this	Certification: To	27. Manner of Death	28a. Date of In (Month, D		28b. Time of		8c. Injun Work		dising ric			jury occurred		77103 1100
	io	uttendin death. ctor: Aff y the fur	atio	1 Natural 5 Pending 2 Accident investigation	(191011111, 12	ay rour,	mjury	M		Yes 2	]No					
	i≤	after death after death Director:	tific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	njury - At he etc. <i>(Specil</i>	ome, farm, str	eet, factor	, office			28f. Location City or 1	(Street rown, St	and Number ate)	or Rural	Route Number,
		oitef c urs af rrel D			<u> </u>											
		To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one)  Certifying Physical Exami	sician: To the bes ner: On the basis and manner:	of examina	wledge, death ition and/or inv	n occurred vestigation	at the tim , in my of	ne, date ar pinio <mark>n, de</mark> a	nd place, ath occur	and due to the red at the time	ne cause e, date a	(s) and mann and place, an	ner as sta d due to	ated. the cause(s)
		o the ithin (	Med	29b. Signature and title of certifier	and manner :	siateu.		290	c. License	e number			29d. I	Date signed (	Month, E	Day, Year)
		ĕ → ₹ →		Marly	P			I	) 5	830	13		PA.	p211 (	0 2	204
	(3	200		30. Name and address of person who co	ompleted cause of	death (Iten	n 23a) (Type.	Print)_			, 1		<u></u>	1		
	·	, v		Agen Church	s M	660	OL N-	Cha	Res	St	136 7	tryme	M	D ZVZ	04	
		Sta		31. Date filed (Month, Day, Year) APR 0 7 20		trar's Signa	iture	P 10								
		Registi	el 💮	MER U / LU	UT	MASS .	A 500 A 500	a O a May	g							

				1 - For State Registrar		of Maryla		artmen ertificat				Reg. No.	004	12704
		Physici /Medic		Decedent's Name (First, Middle Frank George (	Craven						2. Date of De Month	O2	2004	
		Examir	er	4a. Facility Name (If not institution	n, give street and no		CONT	, ,	Town, o	SAL/56	,	4c. Cou	unty of Death	
	3	Funeral	V.	PENINSULA K.  5. Social Security Number	6. Sex		s. last birthday	) If Under		If Under 24 Hrs	8. Date of Bir	th	9. Birth	place (State or Foreign
		Director		214-42-8034	6. Sex 1 M 2 □ F	60	Yrs.	Months	Days	Hours Min	(Month, Da 12-4-1	943		ntry) INSYLVANIA
		and w		Usual Residence of Decedent  10a. State 10b. County		10c. (	City, Town or L	ocation						10d. Inside City Limits
		Maryte f sho	JO.		omico		Delmar							1 ☐ Yes XXNo
		r 28a-	irect	10e. Street and Number				10f. Zip	Code		······	10g. Citizen	of What Cou	ntry?
		th with	alD	29846 Connelly	y Mill Ro	ad			218	75		US	A	
		after deal or Items	uner	11. Marital Status	12. Was De Armed F	cedent Ever in orces? 2 <b>X</b> lo	U.S. 13.	Was Deced	dent of H	tispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. [	Race - Ameri Black, White,	
	36	rs afte	by F	1 ☐ Never Married 2 ☐XMarri 3 ☐ Widowed 4 ☐ Divorced	If Vac G	ive		1 🗆 Yes	a∑ No	Specify:		Spe	ecify: Whi	.te
	9	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show adical Examiner must be notified at	Completed by Funeral Director	15. Deceden	t's Education		16a. Dece	edent's Usua	al Occup	pation	delas	16b. Kind o	of Business/Ir	ndustry
	218	within 7 ene. than "r	nple	(Specify only higher Elementary/Secondary (0-12)	T	(1-4or 5+)	life.			during most of wo	nking	Steel	Co	
	121	Hygier Hygier ther th	Co	17. Father's Name (First, Middle,	l (ast)			Welde	er	18 Mother's Na	me (First, Middle,			
	and	d be f ental f ked of	To Be	George Morris	·						Painter			
	Maryland 21215-0036	12 should be filed within hand Menial Hygiene. 7 Is marked other than "traumatic event, the Med	F	19a. Informant's Name/Relations			19b. Mail	ling Address	(Street		ural Route Numbe			o Code)
	Z,	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Mary Ann Masor	Craven,					y Mill R	oad, Del			
	ore	ges 1 t of He If iter or oth		20a. Method of Disposition 1 □XBurial 2 □ Cremation	3 Removal from	n State	. Place of Disp cemetery, cre	ematory`or o	ther plac		Date		on - City or T	
	Baltimore,	it. Pa intmen intent: njury		`4 □Donation 5 □ Other (S 21. Signature of Funeral Service		Fi	rst Ba		-			Pocomo	ke, Mo	
	Ba	permit. Pages 1 and 2 Department of Health a Importent: If item 27 li any injury or other tra ance.		Carrie of runeral service	hant-a	Journal	1			ss of Facility eral Hom	e, Inc. elmar, D	م 100	40	
	A	Physician /Medical		23a. Part 1. Enter the disease, or shock, or hear ailure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on	caused the de each line.	De notic	nter the mod		ng, such as cardia	c or respiratory ar			Approximate Interval Between Onset and Death
0	М	Examiner			1	7 (01 43 4 001131	04401100 01).			J (	J			
-803-		D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conse	equence of):							
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4.	68	tificate ng phy as the	ledic		0.		_							
THE	). Box 68760	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live	utcome of preg birth 2 Fe gnant at time of nown	etal death 3	□Ectopic pr □ Other (sp		/		23d.	Date of delive Month	ery Day Year
_	P.0	ires that th signed by t d be detach	Phy	9 Unknown  Part II. Other significant condition	ons contributing to	death but not r	esulting in the	underlying c	ause div	en in Part I	23a. Did to	obacco use c	contribute to t	he cause of death?
raven	Vital Records,	uires t signe ld be		Lins C	A		3		2000 g.,	or are are a	12			oably 4 Unknown
à	Ö	law requir as been s 2 should	Completed								24a. Was	an 24	lb. Were auto	opsy findings available impletion of cause of
C	R	The lav ate has page 2	mo								autop perfo 1 Tes	rmed?	prior to co death? 1 \( \subseteq \text{Yes}	
X	/ital	i <b>icien</b> : Th certificate rector, pag	Be C	25. Was case referred to medica examiner?			1				ath (Check only o			
rank	of \	Physicien: r this certificated director,	ဂ္	1 Yes 2 No		Inpatient 2			-	4 🗆 Nul Silly I	Home 5 Resid			<del>ن</del> )
Tr		Attending F r death. octor: After by the funera	tlon	1 Natural 5 Pendir 2 Accident investi	19	e of Injury inth, Day Year)	Injury	от <u>2</u> М	8c. Injur Wor 1 🗆	yat k? Yes 2⊡No	280. Describe i	iow injury oci	curred	
	Division	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this cartificate he completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	ce of Injury - At ding, etc. (Spe	home, farm, s cify)	treet, factory	/, office		28f. Location (S City or Tox	Street and Nu vn. State)	ımber or Rura	al Route Number,
		le Hospite 124 hours le Funere letely fille	edical C	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To th Examiner: On the and ma	ne best of my k basis of exami nner stated.	nowledge, dea nation and/or i	th occurred nvestigation	at the tir , in my o	me, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and date and plac	manner as s ce, and due to	tated. o the cause(s)
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	- /	10mp		30. Name and address of person			em 23a) (Type	, Print) (	leina.	M	2186	4		
		Sta		31. Date filed (Month, Day, Year)	0 6 2004	Registrar's Sig	nature	G,	des	eks				

State of Maryland / Department of Health and Mental Hygiene 2001, 12705 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** LILLIAN KATHERINE CAMPBELL MARCH 2004 Mq8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Nursing and Rehab Center
5. Social Security Number | 6. Sex | 7. Age (In yrs. last bi Salisbury, Md. Wicomico Hours Min. 8. Date of Birth (Month, Day, Yes) If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🂢 F OCEAN CITY, MD. 216-16-7029 91 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Itams 23a or 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director PARSONSBURG WICOMICO MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21849 USA 32016 OLD OCEAN CITY ROAD ould be filed within 72 hours after death Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 HOMEMAKER OWN HOME and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If itam 27 Ia markad any injury or othar traumatic ev. 9008. MAGGIE TRUITT ပ GRIER ATKINS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE LEE - NEPHEW 8954 ATHOL ROAD, MARDELA SPRINGS, MARYLAND 21837 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) SPRINGHILL MEM GDNS. 04-01-2004 HEBRON, MARYLAND Ignature of Funeral Service Lice 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 006 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weeks /Medical Due to (or as a consequence of) Examiner 10 por Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due for as a consequence of): Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 Yes 2 1 No the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Matural death. 1 □ Yes after death I Diractor: 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier cal 1 Gentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 11/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BORINS 1346 S. Division St. Suite, Salisbury, Md. 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ouks MAR 3 0 2004 Registrar

DHMH 17 Rev 1/2001

CAMPBELI

Larry L. Clayborn Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Unpend Item #23a, 27, 25a if per ine 633 Penartment of Health and Mental Hygiene Registrar 04 - 2063**AKG** Reg. No. 2 U 0 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Larry Lee Clayborn March 24, 2004 11:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 44 1/2 East Franklin Street Apt #3 Hagerstown Washington If Under 1 Year | II Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 06/02/1956 Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F 289-52-0636 Director OH Usual Residence of Decedent 10a State 10b County 10c, City, Town or Location 10d. Inside City Limits 28a-f show ral', or items 23a or 28a-f ehov Examiner must be notified at 1 GYes 2 ☐ No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44 1/2 East Franklin St. Apt. #3 21740 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be fited within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 natural, or 1 ☐ Yes 2 No Completed by Specify: Black 3 ☐ Widowed 4 Trivorced Year or Dates: 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I'than Elementary/Secondary (0-12) College (1-4or 5+) Laborer Unknown other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be marked Wallace Lee Clayton Willie Mae Washington 2 if Health and Nitem 27 is man other traumal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Mumford / Sister 115 E. Franklin St., Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or oti once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 03/26/2004 Smithsburg Cremator. Smithsburg, MD 21. Signature of Furreral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition **Physician** Head Injuries resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classor Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physiclan/Medical as esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 2□ No 1 Yes Division of Vital 2 No Yes Hospital or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 ☐ Nursing Home 5 🔣 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1XXes 2 □ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 28b. Time of After 1 Natural Injury 5 Pending 1 Yes 2 No death. investigation 3/19/04 Unknown Subject fell 2 Accident 3 Suicide after death the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Unknown Street 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Certifying Physician: 10 the best of my knowledge, beath occurred at the time, date and place, and due to the cause(s) and mainten as states.

222 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 2. t 1

> State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

32. Registrar's Signature

no completed cause of death (Item 23a) (Type

111 Penn Street, Baltimore, Maryland 21201

29c. License numbe

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 25, 2004

			1 - For State Registrar	State of Ma	•	partment ertificate			d Mental Hy	giene Reg. No.	000	1. 12707
	Physici /Medio		Decedent's Name (First, Middle, Last)     Charles Leon Delor						2. Date of De Month March		65 4	
	Examir Funeral		4a. Facility Name (If not institution, give state) 440 Ridge Avenue 5. Social Security Number 6. Sex	7. Age	(In yrs. last birthd	Hage	ersto	If Under 24	Hrs. 8. Date of Bir	Was	County of De Shingto 9. B	
	Director		218-24-8932  Usual Residence of Decedent  10a. State  10b. County	M 2 F	74 Yrs		Days	Hours	Min. (Month, Di 06/14/1	19. Year) 1929		MD 10d. Inside City Limits
	n the Maryl r 28e-f eho	irector	MD Washingt	ton	Hagersto	DWN 10f. Zip	Code			10g. Citiz	zen of What C	1 X Yes 2 No
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "neturel", or Items 23e or 28e-f ehow entry injury or other traumatic event, the Mudical Exacilities must be inclified at ance.	d by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:	0	3. Was Deceded If Yes, spec	rfy Cuban, ! <mark>∑</mark> No	Mexican, P	? (Specify Yes or No uerto Rican, etc.)		14. Race - Arr Black, Wh	nencan Indian, ite, etc. White
21215-0036	od within 72 h giene. er than *netu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		+) (G	cedent's Usua ive kind of won e. DO NOT usi ain Mas	k done dui e retired)	on ring most of	working		nd of Busines	
Maryland	hould be file d Mental Hy narked oth natic event	To Be (	17. Father's Name (First, Middle, Last) Charles Cleveland	-	105.14			Alice	Name (First, Middle Virginia	Cran	pton	
e, Mai	1 and 2 st Health and em 27 ls n ther traun		Betty L. Miner / 1  20a. Method of Disposition	,		03 Will	l-Ric		ve, Willia	amspo	ort, M	
Baltimore,	permit. Pages Department of I Important: If It eny injury or o' once.		1 Sp Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Rose Hi	.11 Ceme 22. Name and	etery Address	of Facility	/05/2004 Gerald N	Hape Mir	erstown nich F	ı, MD Yuneral Home
	805 g		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	e cause on each line	θ.	enter the mode	of dying,	such as care	. ,		own, M	D 21.740  Approximate Interval Between Onset and Death
	The law requires that the death certificate be executed a large to the law requires that the has been signed by the attending physician and large 2 should be detached for use as the burial-transit	dicai Examiner	disease or condition resulting in death)  Securities at condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	aconsequence of):	0517478	CHR	CIN U	1.4			4 YEARS
Box 6	the death certific y the attending p ched for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	2 ☐ Fetal death	3 □Ectopic pre 5 □ Other (spe				2	3d. Date of de Month	olivery Day Year
rds, P.	w requires that been signed b should be deta		Part II. Other significant conditions con	tributing to death bu	t not resulting in th	e underlying ca	use given	in Part I.		obacco us	_	o the cause of death?
al Reco		Completed							24a. Was autop perfo 1 Yes		24b. Were a prior to death?	utopsy findings available completion of cause of s 2 \( \square\$ No
Division of Vital Records, P.O.	Attanding Physician: If death. sector: After this certified by the funeral director, i	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatien 28a. Date of Injury (Month, Day			Other: lc. Injury at Work?	4 Nursin	g Home 5 Resident 28d. Describe I	dence 6		ecify)
Divis	To the Hospitel or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home, farm, . (Specify)	street, factory,	office		28f. Location ( City or Tox	Street and vn, State)	Number or A	lural Route Number,
	To the Hospitel or A within 24 hours after To the Funeral Direct Completely filled in by	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examination	sician: To the best of ner: On the basis of and manner stat	examination and/o	eath occurred a r investigation,	t the time, in my opin	date and pli ion, death o	ace, and due to the courred at the time,	cause(s) a date and	and manner a place, and du	s stated. e to the cause(s)
)		Σ	29b. Signature and title of certifier	Budja		0	License n			,	signed (Mon	th, Day, Year)
ارز	Y-8 <sup>x</sup>	to.	30. Name and address of person who co  Pamela Fox Bradfo 31. Date filed (Month, Day, Year)	a M L	11110 M		Campı	ıs Rd.	, #130, H	lager	stown,	MD 21742
	Registr	ar	31. Date filed (Month, Day, Year) MAR 3 1 200	14 Benen	1 14. 1	Lacott 1						

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			For Stata Registrar	State of Ma	*	artment of F rtificate of I		Mental Hygie	00-	12700
ı	Physici /Medic		Decedent's Name (First, Middle, Last     BEATRICE LORRAL	,	R			2. Date of Death Month	Day 8 200	3. Time of Death O
	Examin		4a. Facility Name (If not institution, give WASHINGTON COUNTY				Location of Death	1	4c. County of Deat WASHIN	
	Funeral Director		5. Social Security Number 6. S 215-26-8007	ex 7. Age ☐ M 2 💢 F	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) 9. Birti	hplace (State or Foreign untry) ARYLAND
	Maryland	tor	Usual Residence of Decedent  10a. State  10b. County  MARYLAND  WASHI	INGTON	10c. City, Town or Lo		OONCDODO			10d. Inside City Limits 1
	3a or 28e	Il Directo	10e. Street and Number  112 GROVE LANE	.IIGTON		10f. Zip Code	<u>OONSBORO</u> 1713	10g.	. Citizen of What Co	
350	n 72 hours after death with the Maryland "neturel; or items 23a or 28e-f show polest Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	ncan Indian,
9500-6121	i within 72 hou jiene. r then "nature ire Madical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation	(Give	dent's Usual Occupi kind of work done o DO NOT use retired	during most of wor  )	king 16t	b. Kind of Business/	industry
land 2	ba filed Ital Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last) ROY LEON MAY SR.	2		REGISTER	18. Mother's Nan	ne (First, Middle, Mai		
, mary	nd 2 sulth ar 27 is		19a. Informant's Name/Relationship (I		P.O	BOX 335,	and Number or Ru	ral Route Number, C.	ity or Town, State, Z	ip Code)
altimore,			20a. Method of Disposition  1 ☑ Burial 8 ☐ Cremation 3 ☐  4 ☐ Donation ☐ Other (Specify	<i>v</i> )	MOUNTAIN '	natory or other plac	TERY 4/0	1/2004 SF	Location - City or ARPSBURG	MARYLAND
ga	pernit. Page Department of Importent: if any njury or		21. Signature of Fundial Service Licen	Paul M	Dean B	Name and Address	AL HOME	7606 Old Boonsbord	National , Marylar	Pike nd 21713
	Physician /Medical		23a. Par L. Enter the disease, or com shork, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. PAIBU	MM A	or the mode of dylin	y, such as cardiac	or respiratory arrest.		Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. RHBU	Consequence of ):	ARTH	RITIS	\$		KEARS
58760,	ificate be exacuted g physician and as the burial-transit	edical Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					YBARS
O. Box 6	death certii e attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	very Day Year
ras, P	· ~ (/) ¬m	by	Part II. Other significant conditions co	ontributing to death but	not resulting in the ur	nderlying cause give	on in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
al Kecords,	aw as b	Completed						24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
Vision of Vital	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	atlon; To Be	27. Mann of Death Natural 5 Pending 2 Accident investigation	1	28b. Time of	28c. Injury Work	or: 4 🗆 Nursing He	th Check onlone  ome 5 Residence  28d. Describe how in		(fy)
DIVIS	itel or Atte ins after de rel Directo	Certification;	3 Suicide 6 Could not be determined	building, etc.			ī	28f. Location (Street City or Town, St	tate)	
	the Hosp thin 24 hou tha Fune mpletely fil	Medical	(Check only one) Medical Exam	ysician: To the best of ninar: On the basis of eand manner state	xamination and/or inv	occurred at the time vestigation, in my op	inion, death occur	red at the time, date	and place, and due t	o the cause(s)
				7	MA	01	14/2-	100	Date signed (Month,	
54	1-16		30. Name and address of person who all the state of the s	NIV-IM	th (Item 23a) (Type, I	36 MBA	San V	INDR	AAGBA	PRIMIN.
	Sta Registr	- 1	MAR 30 2	.UU4 / Janes	J. B. A.	rede				

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			State of Maryla		epartifica Certifica				giene Reg. No. 🤈 🕦	01	10700
	Physician	1-119 PAI				, -		2. Dete of De Month March	eth	Year 04	3. Time of Death
)	/Medica Examine	4e Fecility Neme (If not institution, give	re street end number)				- 47	Location of Death	4c. County o	of Deeth	
	Funeral Director	242-34-4730	af Road Sex 7. Age (In yrs	71 Y	Months	or 1 Year Days	Hagers If Under 24 Hr. Hours Mir	8. Date of Bir		hingt 9. Birthpla Countr North	con ce (State or Foreign y) Carolina
Menylend	f show	Usuel Residence of Decedent  10a. Stete 10b. County Maryland Washing		ity, Town gerst	or Location	*				100	d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with the	23a or 28a-f si	10e. Street end Number 17301 Cloverleaf	Road		10f. Z	p Code	740		10g. Citizen of Wi		/?
5-0020 72 hours after death with the Merylend	"natural", or thems 23s or 28s-f show solical Examiner must be multiput at leased by Ermannel Discooler	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 🖾 Yes 2 🗀 No 19 If Yes, Give Year or Dates:		13. Was Deci		ispanic Origin? ( In, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Race Black Specify:	- Americar , White, et whi	c.
	d other than "nature event, the Medical B	15. Decedent's Ec (Specify only highest green properties of the control of the co	ducation d ducation ducation ducation ducation ducation ducation ducation d	16e. [		nal Occup ork done o use retired	ation during most of wo	orking	16b. Kind of Bus		stry
and a	Mentel Hygi arked other atic event, T	17. Fether's Neme (First, Middle, Last,	·		Ow.	.101		me <i>(First, Middl</i> e, thleen	Maiden Surname Salter		
Maryland	27 is meri	19a. Informant's Name/Relationship ( Betsy J. Dixon —							or, City or Town, S		
Baltimore,	Department of Health and Mentel Hyglene. Important: If item 27 is marked other than any injury or other traumetic event, the Menone.  To Be Commit	20a. Method of Disposition 1 □ Burial 2 ②Cremation 3 □ 4 □ Donation 5 □ Other (Specification)	Inemoval Irom State	Place of C	Disposition (Na crematory or town C:	me of other plac	е)	Date March	20c. Location - C	city or Town	n, State
Balti Permit.	Importa any Inju	21. Signature of Funeral Service Licer	asee tal				s of Facility M	innich F	ıneral Ho	ome	and 21740
/N	ysician Medical aminer	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	~	cancer the mo	de of dyin	g, such as cardia	c or respiratory ar	rest,	lr C	pproximate iterval Between poset and Death
I RECORDS, P.O. BOX 68/60, The law requires that the death certificate be executed	g physician end es the bunel-trensit		c		nsequence of)						
J. BOX	been signed by the ettendin should be deteched for use leted by Physician/N	Part II. Other significant conditions or	dontributing to death but not re-	sulting in t	he underlying	euse give	en in Part I.	23b. Did t	obacco use contr	ribute to th	ne cause of death?
1S, P.C.	signed by to be detected by the detected by the detected by the detected by the beautiful b							151			oly 4 ☐ Unknown
OIVISION OF VITAL RECORDS, P.O. BOX or Attanding Physician: The law requires that the death certher death car.	ate has been signed by the eitending, page 2 should be deteched for use Completed by Physician/M			in No.				24a. Was a	med?	availa comp of dea	
VITAL	rector, pa	25. Was case referred to medical examiner?	Hospital:			Othe	Vr.	ath (Check only of	16)		′es 2□ No
SION OF	mining to the format blacker. After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	1 Yes 2 No  27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Year)	28b. Tin Inju	ne of	28c. Injury Work	et		ence 6 Other ow injury occurred	1-631	
DIVIS	ins and beautified in by the funere		building, etc. (Speci	fy) 				City or Tow			
the Hosp	the Funer Impletely fill	one)	ysician: To the best of my kno liner: On the basis of examina and manner stated.	wiedge, o	or investigation	, in my op	inion, death occu	irred at the time, o	late and place, and	d due to th	e cause(s)
		29b. Signature and title of certifier	Muhan	M	29	D. License	number		9d. Date signed (		
للحل المساحد	5x1	30. Name end eddress of person you	completed cause of death (Iter	n 23e) (Ty	rpe, Print)		Capo	Rd	3.2	Lun	Ma
•	State Registrar	31. Dete filed (Month De DYear) 9	004 32. Registrer's Signa		Sparke	,		, , ,	7-30-3	,	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dey **Physician** 21 2004 Frances Luella DOARNBERGER March 9:13 p.m. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Williamsport Washington Williamsport Nursing Home If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗓 F Yrs. Director 91 1913 Maryland 214-09-6271 Feb. Usuel Residence of Decedent Pegas 1 end 2 should be filed within 72 hours after death with the Maryland nant of Health and Mental Hygiene. snt: If item 27 is marked other than "natural", or thems 23a or 26a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Depertment of Health and Mental Hygiene. Instruction of thems 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ance. X□ Yes 2□ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21740 924 Chestnut Street U.S.A. Funeral 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 【 No Specify: δ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 0 Clerk Department Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Clara Leah Semler William Lee Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Code) P.O. Box904 Hagerstown, Maryland 21741 Nancy J. Wallech - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 3/25/04 Hagerstown, Maryland 21. Signature of Funeral Service Licensea 22. Name and Address of Facility Minnich Funeral Home w 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or a implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Preumonis 5 DAYS Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that intileted events resulting in death) Last Due to (or as a consequence of): physician end Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): ed by the attanding detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Ferkingon's and þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? this certificata has been siral diractor, page 2 should Completed TL Yes 2KNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4- Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury et Work? Certification: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 5 ☐ Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Medical 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M D33700 March 23, 2004 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Ted E. Howe 154 A 31. Date filed (Month, Day, Year) MAR 24 2004 MO ARTIZAN ST. WILLIAMSPORT, 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar

			1 - For State Registrar	State of Maryland	•		of Health ar	nd Men	tal Hygiene	200	12711
	Physici /Medio Examin	cai	1. Decedent's Name (First, Middle, Last)  OSSIC  4a. Facility Name (If not institution, give:	Douglass	•	4b. City, Tov	vn, or Location of	A	Date of Death Month Da		3. Timerof Death 1
	Funeral Director		5 Social Security Number 6 Sex		ast birthday) Yrs.	If Under 1 Y	ear If Under 24 ays Hours	4 Hrs. 8. 0 Min. 8	Pate of Birth Month, Day, Year) 16 19	9. Bin Co 26 Mar	hplace (State or Foreign ountry) yland
ě,	Sing): Pages 1 and 2 should be filed within 72 hours after death with the Maryland lepstiment of health and Mental Hygiene.  Page Timent of Health and Mental Hygiene.  Page Timent of the marked other than "natural", or items 23a or 28a-f show ny injury or other traumatic event, the Madical Examinal must be multified at Ince.	To Be Completed by Funeral Director	10a. State 10b. County MD 10e. Street and Number 4017 Liberty He	eights Avenue  12. Was Decedent Ever in U.S. Armed Forces?  1	16a. Dece (Give life.) Hous 19b. Mailir 2721 ace of Dispo metery, crer cyland	Te  10f. Zip Co  2120  Was Decedent If Yes, specify  1 Yes 2 S  dent's Usual O kind of work of DO NOT use for See Wife  Lewis station (Name of natory or other Vetera 2. Name and A	of Hispanic Origin Cuban, Mexican, I No Specify: ccupation one during most of attired)  18. Mother's Sara reet and Number of place) an 's 4/ddress of Facility	of working  s Name (First  th Jane  or Rural Roo  A Su  Date  /14/04  J. B	VS Yes or No- 1, etc.)  16b. K  I st, Middle, Maident Queen te Number, City of itland, 1 20c. Lo	14. Race - Ame Black, White Specify: B1 ind of Business/ Private Sumame) or Town, State, 2 Maryland ocation - City or tenham,1 s Funera	rican Indian, e, etc.  ack Industry  Tip Code)  1 20746 Town, State  Maryland al Home
	cate be executed  Physician and Medical Examiner  Sthe burial-transit	dicai Examiner	23a. Part1. Enter the disease or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death.  te cause on each line.  Due to (or as a consequence of the consequence of th			dying, such as ca	ardiac or res		lar	Approximate Interval Between Onset and Death
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		e Completed	25. Was case referred to medical					1	4a. Was an autopsy performed?  Yes 2 No	24b. Were aud prior to d death? 1 ☐ Yes	topsy findings available ompletion of cause of
VISION OT	Attending Phy ir death. ector: After this by the funeral d	ertification: To B	examiner?	-	PVOutpatien 28b. Time of Injury	28c.	Other: 4 Nursi injury at Work? 1 Yes 2 No	28d. [	eck only one)    Residence   Describe how injure	y occurred  d Number or Rui	ify) ral Route Number,
2	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	edical Cert	29a. Certifier 1 <b>駅 Certifyi</b> ng Phys	sician: To the best of my knowner: On the basis of examination and manner stated.	vledge, death	n occurred at the	e time, date and p ny opinion, death	place, and d	ue to the cause(s)	and manner as	stated. to the cause(s)
	To the comp	Me	29b. Signature and title of certifier  Amatun  A		MI	DI	ense number	03	29d. Dat	e signed (Month	Day, Year) 7 2004
i	Sta Registr		30. Name and address of person who co my full H H 31. Date filed (Month, Day, Year)  APR 0 9 2004	mpleted cause of death (Item  22. Registrar's Signatu	501	Do	phin	, 57	reet 1	Balte	, 17/1) 2/2/7

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9:23 P M 2004 Herbert L. Dickerson April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**∑**M 2□F Yrs. Director July 8, 1942 Maryland 215-38-1898 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show 1X Yes 2 □ No Director Prince George's Ft. Washington Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9902 Traverse Way 20744 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □XYes 2 □ No If Yes, Give Year or Dates: 5 1 ☐ Yes 21 No Specify: Specify: Black. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Emergency Planner Government - USDA or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) phrough pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 900s. Be Elva Dickerson Benjamin Franklin Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9902 Traverse Way, Ft. Wash., MD Juana A. Dickerson - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 Donation 5 Dother (Specify) Maryland Veterans Cem. 4/12/2004 Cheltenham, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee Tewar 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebral edema **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner erebrovascylar accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed?
Yes 2 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ➤ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2XNo 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after deat unerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ope) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nurs OL Sumau MD D0053813 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

APR 0 9 2004

MD

32 Registrar's Signature

Syrratts Road

Dumais,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** DELGADO ARMELO VELEZ 04 12:50 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner ATONSVILLE

If Under 24 Hrs. 8. Date of Birth
Hours | Min. (Month, Day, Year HAVEN NURSING HOME BALTIMORE 6. Sex 1404M 2□ F 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Days Yrs. 582-28-5176 1931 Puerto Rico July 16, Director 72 Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Funeral Director Glen Burnie 1X Yes 2 □ No MD Anne Arundel 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21060 USA 5847 Americana Circle #T3 Baltimore, Maryland 21215-0020

Comit. Pages 1 and 2 should be filed within 72 hours after death vol. ariment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural; or items 23s and hyllogry or other traumatic event, tra Medical Examiner must once. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1X Yes 2 □ No Specify: þ Specify: Puerto Rican 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Maintance Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Nicomedes Velez Lino Delgado 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5847 Americana Circle, T3, Glen Burnie, MD Janie Delgado/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenwood Union Cemetery 4/7/04 Rye, New York 22. Name and Address of Facility

Johnson & Jenkins Funeral Home, Inc. 21. Signature o Funeral Service Licensee 716 Kennedy Street, NW, Washington, DC 20011 23a. Phot. Enter the disease, or complication of that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cay se on each line. Approximate Physician Immediate Cause (Final disease or condition resulting in death) /Medical udden Examiner by Physician/Medical Examiner eavs The law requiras that tha daath certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, physician Due to (or as a consequence of) attanding p Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uee contribute to the cause of death? 3 Probably 4 → thknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy ata has b 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 2 100 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After this
complataly filled in by the funeral 27. Mann 1 Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) To the 29b. Signature and Rie of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Ferry Rd Linthieum med 21090 800 Hammunds MA WD

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 5 2004

32 Registrer's Signeture

Physici Medic/		1. Decedent's Name (First, M David Dee		t)	4,BWW,Mo W,McCo					2. Date of De Month April	Day 5	2004	4 9:17 <del>★</del>
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D _	_		For State Registrar			larylan		artment of tificate of		d Mental H	Reg. No 2	004	12715		
	Physici /Medic		1. Decedent's Nam HADRIA		First, Middle, Last) RASVAN DUMITRESCU					2. Date of Death Month, April 5, 2004  1025					
	Examir				give street and number	)			or Location of D	eath		ounty of Deatl			
		ш	Suburbar			(	and block days	Bethes		Hrs. I a a		Montgomery			
*	Funeral Director		5. Social Security N 555-85-5	Sex 7. A	35	ast birthday) Yrs.	Months Days		Ain (Month, L	Oey, Year) 1, 1968 9. Birthplace (State or Foreign Country) Romania					
	land		Usuel Residence of 10a. State	10b. County		10c. City, Town or Lo			ocation				10d. Inside City Limits		
	Marylan -f ehow lied at	ğ	Md.	Montgo	omery	nery Gaithersh						1 <b>X</b>			
	r 28g	irec	10e. Street and Nu						· · · · · · · · · · · · · · · · · · ·		10g. Citizer	n of What Cor	untry?		
	th wit	a D	420 Girard Street #103					2	20877		Unite	d Stat	es		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show may injury or pither treumatic event, the Modical Examinar must be notified at ance.	Completed by Funeral Director	11. Marital Status 1    Never Marr 3    Widowed	ied 2 Marrie	Armed Forces  1 ☐ Yes 2 [X]  If Yes, Give	1 ☐ Yes 2 ☒ No If Yes, Give			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:				14. Race - American Indian, Bleck, White, etc.  Specify: White		
8	hour	ed t	3 711001100	15. Decedent's		Year or Dates:  ucation 16a. Deced			nation		16b. Kind of Business/Industry				
21215	I within 72 liene. r then "na the Medic	omplet	(Spec	cify only highest	grade completed)	College (1-4or 5+)			during most of ad)	working	Retail				
Maryland 21215-0036	old be filed lental Hyg rked other lic event,	To Be C	17. Father's Name Valenti							Name (First, Middl eta Neas		mame)			
ary	shou and N	-	19a. Informant's N	ame/Relationship	(Type, Print)		19b. Mailin	g Address (Stree	t and Number or	Rural Route Num	ber, City or T	own, State, Z	ip Code)		
	and 2 salth in 27 i		Valenti	n Dumitr	escu (Fath				reet #1	03 Gaith	ersbur	g, Md.	20877		
ore	T S T T T T T T T T T T T T T T T T T T		20a. Method of Dis		☐Removal from State		ace of Dispo metery, cren	sition (Name of natory or other pla	Ap)	ril 10,	20c. Local	tion - City or T	own, State		
Ë	Pag Iment tant:		` 4 ☐ Donation	5 Other (Spe	cify)	St.		s Cemet	ery   20	004		ille,	Md.		
Baltimore,	permit Depart Import eny in		21. Signature of Fu	tic E.	Day		1	Name and Address  O East D	ess of Facility Peer Par	DeVol Fui k Dr. Gai	neral l ithers	Home burg, 1	Md. 20877		
Physician /Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not ensure the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Due to (dr as a consequence of):						us of			mity in			Approximate Interval Between Onset and Death			
,	be executed sician and burial-transit	ical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	5	Due to (or as a consequence of):  C										
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P.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months? ☐ No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	Fetal death 3 Ectopic pregnancy					23d. Date of delivery Month Day Year			
	ires that the de signed by the I be detached	Certification: To Be Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did toba.							5.4	acco use contribute to the cause of death?				
of Vital Records,	e law require has been si je 2 should b									24a. Was	s an 2	4b. Were auto	opsy findings available ompletion of cause of		
a						performe 11X Yes 2□						death?	2□ No		
Z Z	Physician: this certificant all director,		25. Was case refer examiner?		Hospital: 1 Vigoration: 2   FR/Outpetient 2   DOA Other: 4   All All Angle All Angle										
	ding Phys h. After this funeral di		1XX es 2 ☐ 27. Manner of Deat 1 ☐ Natural		28a. Date of Injury 28b. Time of Month. Day Year)  28b. Time of Work?  28c. Injury at Work?										
Division	or Attending after death. Director: After In by the fune		2 Accident 3 Suicide	investiga: 6 Could no determin	t be 28e. Place of In	3-30-04 9:36 PM 10			1 - Yes 2 ANO redestrian			Struck by a motor Whi et and Number or Aural Route Number or Rural Route Number.			
Ö	s after s after of Dire	Cert	4  Homicide		building, e	building, etc. (Specify)  City or Town, S						Drive Bethesde mo			
	To the Hospital or Attending Physician:  -within 24 hours after death:  - othe Funerel Director: After this certific  completely filled in by the funeral director.	edical (	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examinati	vledge, death	occurred at the ti	me, date and pla opinion, death o	ace, and due to the courred at the time	cause(s) and	manner as s	stated.		
	To the sound	ž	29b. Signature and					29c. License number 29				9d. Date signed (Month, Day, Year)			
	4		P ~	y wi.	m, D			0.C.	M.E.		April	6, 20	004		
			30. Name and addr		no completed cause of a				t, Balt	imore, Ma	aryland	1 21201			

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) APR 0 8 2004

ORIGINAL

32. Registrar's Signature

			1 - For AMEND#20b, cperCen Registrer AMEND#22perFFH/	State of Marylan	d / Depa	artment o	of Heal	th and M	ental Hy	giene	nnı	10710
			1 - State AVEND#200, CDETCH1 Registrar AMEND#22per FH4/	16/04, EW,Mcc	V, MCe	rtificate	of Dea	ath	2. Date of De	Reg. No.	UUU	12/16
п	Physici		1. Decedent's Name (First, Middle, Last)  Joyce L. Dozi	er					Month 04	Day	2004	3. Time of Death  1:11 pm
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Tov	vn, or Local	tion of Death	01		unty of Death	1.11pm
			111513 Lockwood					Sprin	<del></del>		ntgome	
4	Funeral Director		5. Social Security Number  577 64 7602  Usual Residence of Decedent	7. Age (In yrs. 55	last birthday) Yrs.	If Under 1 Y Months D	ear If Ur ays Hou	nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da 06/2	h y, Year) j 4 8	9. Birthp Cour N • C	place (State or Foreign ntry)
	yland now		10a. State 10b. County	10c. Cit	y, Town or Lo	cation	<u> </u>				1	0d. Inside City Limits
	e Marian	ctor	Md Montgom	ery S:	ilver	Sprin	ıg					1 ☐XYes 2 ☐ No
	with th	Funeral Director	10e. Street and Number 111513 Lockwoo	.d Dr #7		10f. Zip Co 209					of What Cour	ntry?
	ns 23	eral		2. Was Decedent Ever in U	.S. 13. 1	Was Decedent	of Hispanie	c Origin? (Spe	cify Yes or No-		SA Race - Americ	an Indian,
980	d within 72 hours after death with the Maryland jiene. r than "natural", or flems 23a or 28e-f show the Medical Evantiver must be trofiffed at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify 1 ☐ Yes 2 🔀	Cuban, Me	xican, Puerto	Rican, etc.)		Black, White, ecify: B]	etc. Lack
5-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usual O kind of work d DO NOT use n	ccupation one during	most of worki	ng	16b. Kind o	of Business/Inc	dustry
21215-0036	77 75 14 175	To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 3yrs	life. I	Probat	ion	Offic	er	Gove	ernmer	nt
ng	be filed stal Hygi ad other avent, I		17. Father's Name (First, Middle, Last)	n+					(First, Middle,		name)	
Maryland	should be nd Mental markad o		George O. Blou	11.00	106 14-16-	- Address (C			B. Eng		- Ch. T	0.11
	d 2 h a 7 h a 7 h a train		George O. Bloun						Farmv			
Baltimore,	of of		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Dispo Profession PCSEWO	sition (Name of nator or other od Co	rery mete	4-16-0	34 /17/04	20c. Locati Suitla Fare	on City or To and, Ma	wn, Stete ary Land
	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service License	• 2	22	Name and A	T THILE	Transfer in	hall's h Sthatc NW W	nerall N.W. W ashir		DC 20011
	- 26		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat e cause on each line.	h. Do not ent	er the mode of	corg dying, such				ig tun,	Approximate Interval Between
	Physician	ner	Immediate Cause (Final disease or condition	AMEROSCLER	RONC	HEAR-	T DIS	EASE.			8	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):							
	# # # # # # # # # # # # # # # # # # #		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	be executed sician and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	Due to (or as a consen	uence of):							
760,	ite be ex nysician ne burial	calE										
9	tificate ig phys as the		0.									
.O. Box	he death certificat the attending phy ched for use as th	edical Certification: To Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ac. If yes, outcome of pregnations of the second of the s	Ideath 3	Ectopic pregn Other (specif				23d.	Date of delive Month	ry Day Year
<u>α</u>	The law requires that the de site has been signed by the z bage 2 should be detached i		Part II. Other significant conditions conf	tributing to death but not res	ulting in the ur	nderlying cause	e given in P	art I.	23e. Did to	bacco use c	ontribute to th	e cause of death?
rds	w requires been signe should be		HUPERTSNSION						1 <b>☑</b> Y	es 2 🗆 No	3 ☐ Prob	ably 4 Unknown
Vital Records,	e law re has be je 2 sho		*						24a. Was a autop	sv	prior to con	osy findings available inpletion of cause of
al H										2 No	death?	2□ No
Κ			25. Was case referred to medical examiner?  1 Yes 2 No	0.1	26. Place of Death (Check only one)  17. 4 □ Nursing Home 5 M Residence 6 □ Other (Specify)							
ا و ر	ding Phys h. After this funeral di		27. Manner of Death	1 Limpatient 2 Lien/Outpatient 3 Libox 4 Linursing Hom					28d. Describe how injury occurred			
sior	Attending r death. sctor: After by the fune		2 Accident investigation M 1 Yes 2 No									
Division	Dir		4 Homicide determined determined building, etc. (Specify)									
	Hospital or 24 hours afte Funeral Dir stely filled in		29a. Certifier 11 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the control of the contr	ne time, date my opinion,	e and place, a death occurre	nd due to the o	ause(s) and late and plac	manner as sta e, and due to	ated. the cause(s)
	To the Youthin 2 To the Complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Lic	cense numb	Der Der	2	9d. Date sig	ned (Month, L	Day, Year)
	5	The state of the s	D/0, (3/1)	1 1 x	2.	DC	113	3778		041	07/04	
			30. Name and address of person who cor	npleted cause of death (Item	23a) (Type,	Print)	0315	Desino	5 /A 1 130 s	D. A.		20027
	* C40	to	THOMAS TESORIERO  31. Date filed (Month, Day, Year)	FAISEL PERLI		12 21	00 W	LENIZ.	20100	ANT W	SNW	2005/
82	Sta Registr		APR 0 8 200	4 Senera	B	door	Kal					

		•	For State	State of Ma	arylan		artmen rtificate			and M		gien	711	04	127	18
	Physicia	an	1. Decedent's Neme (First, Middle, L  I.i We  I.i We	ast) n Dong							2. Date of Dea Month March 3	ath Di		Yeer	3. Time of Dea	ath P M
	/Medic Examin		4a. Fecility Name (If not institution, gr Shady Grove Adver	ive street and number)	tal		R	ockv	Location o	of Death		4	c. County o	gome	ry	
	Funeral Director		5. Social Security Number 6. 393-94-1258  Usuel Residence of Decedent	Sex 7. Ag 1 ☐ M 2 🖾 F	e (In yrs. 46	last birthday) Yrs.	II Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birt (Month, Da) Sept. 1	h y, Year 7, ]	957	9. Birthp Coun Ch	olece (Stete or Fo ntry) ina	reign
	e Maryland Ba-f show	Director	10a. State 10b. County  Maryland Montgot	mery		y, Town or Lo North	Potom					10.0	itizen of WI		0d. Inside City Li	
	h with th	ai Dire	13526 Hunting Hi	.11 Way			10f. Zip	2087	8				ited		,	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injuryer other traumatic event, Ita Medical Examinal mutual to multified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1	Was Deced II Yes, spec		spanic Ori n, Mexican Specify:		cify Yes or No- Rican, etc.)	-		, White,	ean Indian, etc. Asian	
Maryland 21215-0036	within 72 housene. Then natural	Completed	15. Decedent's (Specify only highest g	Education rade completed)  College (1-4or:	5+)	(Give	dent's Usua kind of wor DO NOT us emist	al Occupa rk done d se retired	ation furing mos	t of workii	ng		Kind of Bus		ŕ	
land 2	uld be filed Mental Hygie irked other itic event, it	To Be Co	17. Father's Name (First, Middle, Last Fengqi Dong						18. Mothe		(First, Middle, huyuan	Maide				
Mary	nd 2 shouth and N		19a. Informant's Name/Relationship Quanhe Ma/Husbar				•	,			North P				code) Land 208	78
Baltimore,	Pages 1 and Heat of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec			Place of Disponentery, cre Lional				Apri 200	1 8, 4			urch	, Virgin	
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Lic	~		0190 75	57 Wis	cons	in Av	7e., E	uneral Sethesda	a, M	ne/	Cha		•
4	Physician /Medical		23a. Pert1. Enter the disease, or co shock, or fleart failure. List on Immediate Cause (Final disease or condition resulting in death)	a Intra	cere	bral H			g, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Deat 14 days	n h
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	red	Brain	Aneur	ysm						1	14 days	
68760,	e be executed ysician and e burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consec	quence of):										
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٥.	sign d be	by	Part II. Other significent conditions	s contributing to death t	out not res	sulting in the u	underlying o	ause give	en in Part I	٠	14				he cause of death pably 4 ⊠Unkn	
I Records,	The law ate has t page 2 s	Completed									24a. Was autop perfo 1 - Yes	rmed?	pr de	ere auto fior to con eath? Yes	ppsy findings avai mpletion of cause 2X No	lable e of
Vital	Physician: Th this certificate ral director, paç	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2	] ER/Outpatie	nt 3 DC	Oth	ar:		n <i>(Check only o</i> me 5 ☐ Resid		6 ∏Othe	r (Snacif	(v)	
of	ling After lune	-	27. Manner of Death 1 🖫 Natural 5 🗆 Pending 2 🗀 Accident investigat	28a. Date of Inj. (Month, Da	ury	28b. Time of		28c. Injun Worl			28d. Describe t				7	
Division	tal or Attend rs after death al Director:	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ed 289. Place of in building, e	tc. (Speci	ify)					City or Tov	wn, Sta	ite)		al Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medicai	29a. Certifier 1 ☑ Certifying (Check only 2 ☐ Medical Ex	Physician: To the best aminer: On the basis and manner s	of my knoof examinated.	owledge, dea ation and/or ii	th occurred nvestigation	at the tin i, in my o	ne, date ar pinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause date a	(s) and man nd place, a	ner as s nd due to	tated. the cause(s)	
	To th withir To th	M	29b. Signature and title of Centifier			pr			e number				ate signed $1$ ,			
	15		30. Name and address of person w							Rockv	ille, N				850	
	St Regist	ate rar	31. Data filed Month, Day, Year)  APR 0 5	32. Regist		ature /	/	rock		LOCKY		-u ± )	, Lunu			

			1 - State Registrar	State of Maryla		artment of F rtificate of			jiene 004	12720
		1	Decedent's Name (First, Middle, Last	)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physici: /Medic		Michael Earl Di	tch				March		3:00 P M
	Examin		4a. Fecility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of Death	
			816 Easley Stree	et Apt. 835		Silver			Montgomer	у
	Funeral		5. Social Security Number 6. Se	ZIM OULE	rs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	Year) 9. Birth	olace (State or Foreign ntry)
*	Director		223-64-2379 Usual Residence of Decedent		58 Yrs.			Feb. 21	, 1946   Cali	fornia
	land		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary	io	Maryland Montgon	10.777	Silver	Spring				1 ☐ Yes 2 No
	1 the	Director	10e. Street and Number	iery	BILVEL	10f. Zip Code		1	Og. Citizen of What Cou	ntry?
	3a o		816 Easley Street	., #835		2091	0		USA	
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-	14. Race - Americ	
9	or Its		1 Never Married 2 Married	1 X Yes 2 No		1 ☐ Yes 2 ☒ No	Specify:	nican, etc.)	Specify: White,	
8	ours raf.	d by	3 ☐ Widowed 4 🖾 Divorced	Year or Dates:1966	5-1968	10163 213110	Specity.		Specily. Will	
2	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show the Mscleal Evanting frauk be indiffed at	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	ng	16b. Kind of Business/In	dustry
12	withir sne. then	d H	Elementary/Secondary (0-12)	Coltege (1-4or 5+) 2			ance Inspe	ator	Electronic	C
2	Hygie Hygie ther		17. Father's Name (First, Middle, Last)		Quai	ity Assul	18. Mother's Name			.5
an	d be	Be c	William Earl Dito	:h				Kathryn	,	
Maryland 21215-0036	Shoul od Me mark mati	2	19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (Street	·		r, City or Town, State, Zip	Code)
	nd 2 lith a 27 Is r trau		William E. Ditch/	' Father	821 L	ake Port	Boulevard	, S211,	Leesburg,	FL 34748
Ē,	f Height		20a. Method of Disposition		o. Place of Dispo	sition (Name of matory or other place	Ce) D	ate	20c. Location - City or To	own, State
Ë	Page Int. H		1 ☐ Burial 2 ☑ Cremation 3 ☐ I  '4 ☐ Donation 5 ☐ Other (Specify,			Ltan Crema	- Phri		Alexandria.	Virginia
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural; or items 23a or 28a-1 show among injury or other traumatic event, the Medical Examinet must be notified at an once.		21. Signature of Funeral Service Licens		2	2. Name and Addre	ss of Facility			
m	# 9 E # 8		(inchew 5	Cole	5	rancis J. 00 Univer	. Collins csity Blvd	Funeral W., S	Home Inc. ilver Sprin	g, MD 20901
F			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the d						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Atherosclen	stic Co	irdiovas	cular )	iseare		Onset and Death
r Ar	/Medical		resulting in death)	Due to (or as a cons						
	Examiner		Sequentially list conditions	b						
	Sit ad	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):					
	and I-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):					
8760,	cate be executed physician and the burial-transit									
387	cate phys s the	dicai		d						
9 x	that the death certifined by the attending I detached for use as	Physiclan/Me	tF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date of delive	erv
Вох	death atter	clar	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)	y		Month	Day Year
o.	the can be ached	hysi	9 Unknown	9□ Unknown						
σ,	The law requires that the tee bas been signed by the base been signed by the bage 2 should be detache	by P	Part II. Other significant conditions co	intributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to the	he cause of death?
rds	quire en sig uld b	ed b						1 □ Ye	as 2□No 3□Prob	pably 4 Munknown
Vital Records,	aw re	Completed						24a. Was a		psy findings available mpletion of cause of
Ä	The law ate has page 2:	E O						perforr	ned? death?	2 No
ita	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Death			
	si ib	To	1XXYes 2 □ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatier	nt 3□ DOA Oth	ner: 4 Nursing Hon	ne 5 🗆 Reside	ence 6 Other (Specif	wAt scene
0	ding Pl h. After tl funera		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Wor	rk?	8d. Describe ho	ow injury occurred	
sio	Attending r death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division of	or At fter d Sirect in by	Certification:	4 Homicide determined	28e. Ptace of Injury - A building, etc. (Spe		eet, factory, office	2	18f. Location (St City or Town	reet and Number or Rura n, State)	il Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 ☐ Certifying Phy	(gician: To the best of con-	knowledge de-	h accurred at the co	mo date and sizes	and due to the	2000/a) and	totad
	Hos 24 ho Fun stely f	edical		/sician: To the best of my liner: On the basis of examand manner stated.						
	o the o the omple	Med	29b. Signature and title of certifier	and market stated.		29c. Licens	e number	2	9d. Date signed (Month,	Day, Year)
	- 5 - 8		I hi a	m. D		O.C.M	.E.	M	arch 23, 20	04
	5		30. Name and address of person who c	ompleted cause of death (	tem 23a) (Type.				, 10	
			LING LI. M	i D			enn Street	, Balti	more, Maryl	and 21201
1	Sta		31. Date filed (Month, Day, Year) APR 0 5 20	32. Registrar's Si		Spark				
	Registi	ar	HER UU 20	The state of the s	1	jupour.				

			1 - For State Registrar	State of Maryla		artment of <i>rtificate o</i>		ind Men	tal Hygien	200	12721
	Physici /Medic	cal	Decedent's Name (First, Middle, Le     MAGDELINE     4a. Fecility Name (If not institution, gir	DILLOW		4b City Town	n, or Location o	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	74 - 0	eay Year	04 6:45AM
	Examir Funeral Director	ier	FAIRLAND ADV 5. Social Security Number 6.1 184-18-5616	ENTIST NSG. R	. last birthday)		ILVER	24 Hrs. 8. D Min.		MONT 6	
	he Maryland 8a-f show olified at	ector	Usual Residence of Decedent           10a. State         10b. County           MD         Prince		city, Town or Li						10d. Inside City Limits 11☑Yes 2 ☐ No
036	be filed within 72 hours after death with the Maryland nat Hygiene. od other than "natural", or Hems 23a or 28e-f show event, the Medical Examinar must be motified at	by Funeral Director	10e. Street and Number  7800 Hanover Pkw  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Y •  12. Was Decedent Ever in Amed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1	10f. Zip Code  2077  Was Decedent of If Yes, specify C	'O of Hispanic Orig uban, Mexican	gin? (Specify \ , Puerto Ricar	υ	I.S.A.  14. Race - Ar Black, W	merican Indian,
21215-0036	d within 72 ho giene. ir than "natur ir the Medical	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 1 2		(Give	dent's Usual Occ kind of work dor OO NOT use ret maker	cupation ne during most ired)	of working		Kind of Busines	ss/Industry
Q	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M	0	17. Father's Name (First, Middle, Las Michael Kertesz	,	105 14-31	4.44 (04	Hel	en Sim	·		7.0.0
re, Mai	s 1 and 2 st f Health and item 27 ts n other traun		19a. Informant's Name/Relationship Dary1 R. Dillow 20a. Method of Disposition	- Son 20b.	7800	ng Address (Stre Hanover osition (Name of matory or other p	Pkwy.		elt, MD		
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ı	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only timmediate Cause (Final disease or condition resulting in death)	polications that caused the dear one cause on each line.  Acute myoca  Due to (or as a conse	ath. Do not en	ter the mode of d	lying, such as				Approximate Interval Between Onset and Death
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O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	⊒Ectopic pregnar □ Other (specify)			1	23d. Date of d Month	lelivery Day Year
rds, P	quires that en signed b uld be deta	þ	Part II. Other significant conditions H/O copd	contributing to death but not re	sulting in the u	inderlying cause	given in Part I.	2	?3e. Did tobacco 1		to the cause of death?  Probably 4  Unknown
al Records,	The ate h	Completed	Severe degenerati	ve joint dise	ase				4a. Was an autopsy performed? □ Yes 2 N	prior to death?	
ion of Vital	Attending Physician: Tr death. sctor: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5  Pending investigatic investigatic	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. In	Other: 4 🖾 Nur	28d. C	ack only one)  Carlo Residence  Describe how inju		pecify)
Division	To the Hospital or Attendi within 24 hours after death. • To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined		home, farm, sti ify)	reet, factory, offic	e		ocation (Street a lity or Town, Stat		Rural Route Number,
	the Hosp thin 24 hou the Fune mpletely fil	Medical		hysicien: To the best of my kn miner: On the basis of examin and manner stated.		vestigation, in my			the time, date ar		ue to the cause(s)
	J V V		· /leg	VSSC		D4.	5471			-6-04	ini, Day, real)
			30. Name and address of person who Yeheyis Negusia	e, M.D. 1111 S	pring S	t. Suit		ilver	Spring,	MD 209	04
	Sta Registi		APR 0 7 20	32. Registrar's Sign	S	Spork.	211				

			1 - For State Registrar	State of Ma	arylar		artmer	nt of H	lealth an Death		ntal Hygie	ene . No 2 (	) () L <sub>3</sub>	1273	22
			1. Decedent's Name (First, Middle, Last)								Date of Death Month	Day	Yeer	3. Time of De	ath
	Physici /Medio		Gracieuse Carme	el Desir							ril		2004	8:25 A	М
	Examir		4a. Facility Name (If not institution, give s				4b. City,	Town, or	Location of E	Death		4c. Cour	ty of Death	1	
			3 Drum Castle Cour	:t			G	erma	ntown			Mon	tgomen	У	
	Funeral Director		5. Social Security Number  591-26-4694  Usual Residence of Decedent	7. Age	9 (In yrs. 75	last birthday) Yrs.	If Unde Months	Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, Y Irch 31,	<sub>ear)</sub> 1929	9. Birthp Court Hai	lece (State or Fo try) ti	oreign
	Maryland a-f ahow iffied at	ctor	10a. State 10b. County MD Montgome	ry	10c. Ci	ty, Town or Lo	ocation	G	ermanto	own			1	0d. Inside City L	
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ire	10e. Street and Number				10f. Zip	Code			10g	. Citizen o	f What Coun	try?	
	1h wi	a	3 Drum Castle Cour	't				2087	6			Hait	i		
036	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f ahow any injuly or pother traumatic avant, the Madical Engineral instituted any injuly or pother traumatic avant, the Madical Engineral instituted and once.	by Funeral Director	11. Marital Status 1  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	2. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		-	Was Dece If Yes, spe	77	spanic Origin' n, Mexican, P Specify:	? (Specify Puerto Rica	Yes or No- an, etc.)	В	ace - Americ lack, White, cify: Bla	etc.	
9	72 ho natur lical	ted	15. Decedent's Educ (Specify only highest grade	ation		16a. Dece	dent's Usu	al Occupa	ation furing most of	function	16	b. Kind of	Business/Ind	dustry	
2121	ed within regions.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	Homem	se retired	) 	WORKING		Own 1	Home		
Maryland 21215-0036	should be tile tod Mental Hy s marked oth umatic avant	To Be (	17. Father's Name (First, Middle, Last) Dorceus Desse						18. Mother's Altida		rst, Middle, Mai rva1	iden Suma	ате)		
, Mar	and 2 sho salth and n 27 ls m ar traum		19a. Informant's Name/Relationship (Type Luc Desir / Son	e, Print)		3 Dru	ım Ca	stle	Court,		oute Number, C mantown		n, State, Zip 2087	_	
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Balt	permit. Departr Importe any inji		21. Signature of Funeral Service License	tuver).					s of Facility Orive,	DeVo Gait	1 Funer hersbur	al Ho	ome, 1 0 2087	0 East 7	
i	Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause on each lin	Θ.	h. Do not ent								Approximate Interval Betwee Onset and Deat	
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I Kecords,	alcian: The law re certilicate has bee rrector, page 2 sho	Completed								_	24a. Was an autopsy performed	12	Were autop prior to con death? 1  Yes	sy findings avail	lable of
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010	S D	2	1 ☐ Yes 2 ☑ No Ho	ospital: 1 🗌 Inpatier	nt 2 🗆	ER/Outpatien	1 3 DC	A Othe	r: 4 🗌 Nursin	ng Home	5 Aesidence	e 6 □0t	her (Specify)		
	ling After une		27. Manner of Death 1 ☑ Matural 5 ☐ Pending 2 ☐ Accident	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	M 2	8c. Injury Work	at	28d.	Describe how i	njury occu	rred		
DIVISION	tel or Attand rs after death al Director: ed in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	. (Specif	y)					City or Town, S.	tate)		Route Number,	
	To the Hospitel or A within 24 hours after To the Funeral Direc completely tilled in by	Medical	29a. Certifier 1 ☑ Certifying Physi (Check only one)	ician: To the best o er: On the basis of and manner stat	examina	wledge, death tion and/or inv	occurred restigation,	at lhe time in my op	e, date and plainion, death o	lace, and o	due to the cause the time, date	e(s) and m and place	nanner as sta , and due to	ited. the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier				290	. License		_		-	ed (Month, D		
	1		Repl Moa					Do	7110	Ĺ	A	PRI	45,	2004	
	•		30. Name and address of person who con					V	. d	3.00					
	Sta	.0	Ralph M. Coan, M.]	32. Røgistra			eet,	kens	ington	1, MD	20895				
8	Sta Registr		APR 0 8 2004		ريسم	19	200	aks.	1						

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Dey P **Physician** 20. NICOLE CASSARA DAWKINS MAR 2004 9:05 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 ☐ M 2 🂢 F Yrs. N/A Director 29 MAR 2004 MARYLAND. Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits ai Hygiene. I other than "naturel", or items 23e or 28a-f show vent, the Medical Examiner must be malified at 1 ☐ Yes 2 X No Completed by Funeral Director MD MONTGOMERY ROCKVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14006 PARKLAND DRIVE 20853 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Ie marked other than "naturel", or Itel 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 0 treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHEVAUX DAWKINS 2 ROSHAWNA HELENE COBB 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 ie
eny injury or other treu - FATHER CHEVAUX DAWKINS 14006 PARKLAND DRIVE ROCKVILLE MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Alexandria, VA 4 □Donation Funeral Srv 4/5/04 5 Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signatur / 1 Juneral Service Licens 246 N. Wash. St., Rockville, MD 20850 23a. Pert1. Enter the disease, dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EXTREME PREMATURITY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 2 Fetal death 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes ₹□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₩ No Hospital: 2 ER/Outpatient 3 DOA 2 1 v Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t or Attending Injury 5 Pending investigation 1 XNatural 1 Tes 2 🗌 No within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 - Homicide 15 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0101233385 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 E. BROWN USNR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Da **Physician** 2, Khanh H. Dao April 2004 12:50 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year Anril 14, If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1**X** M 2 □ F Months Year) Director 219-29-4972 84 1919 Vietnam Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Takoma Park Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8608 Flower Avenue #C4 20912 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status illed within 72 hours after thygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Asian Specify: þ 3 X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief District Politics permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injuryor other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thuy H. Dao Diem T. Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Ta/Niece 2118 Queensguard Road, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of camatary, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State April 4. 1 ☐ Burial 2 【▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Bethesda, Maryland 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Euneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical use as signed by the attending it be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Tyes 2 No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 21 Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes NO 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day 32. Registrar's Signature State APR 0 5 2004 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registre Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 145] WILTON Danie 300 45-City, Town, or Location of Death Facility Name (If not institution, give street and number) **County of Death** 0 Ú umpla If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Menth, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days TOM 20 F Months Hours 231-05-4962 12/27 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√2 No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 3122 Gracefield Road, #214 United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. TY□Yes 2□No If Yes, Give WWII Year or Dates: 1 Never Married Marned 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0.12) College (1-4or 5+) Electrical Estimator Electrical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert William Daniel Virgil Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty C. Daniel -wife 3122 Gracefield Road, #214 Silver Spring, Md. 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 4/5/2004 Brentwood, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Andress of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 21. Signature of Funeral Service Licenses oneld Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK 30241 disease or condition resulting in death) Due to (or as a consequence of): Prouver (A 5 DA45 Sequentially list conditions, if any, leading to immediate the first process of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Date of delivery Month Day Year contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 700

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

the

? is marked other then "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner mast be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or important: if item 27 is marked other then "natural", or items 23a or any injury or other traumatic event, the Madical Examinet result to once.

Baltimore, Maryland 21215-0036

Funeral Director

Completed by

Be

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To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical P þ Completed 2 Be Medical Certification: To 2

F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery  Month Day Yea
art II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat
Insmorty	<u> </u>	1 Probably 4 □Unki
Bullous i	mpurpom	24a. Was an autopsy findings ava prior to completion of caus death?  1
5. Was case referred to medical	26. Place of De	ath (Check only one)
examiner?	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)
7. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  28c. Injury at Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number City or Town, State)
	i ysician: To the best of my knowledge, death occurred at the time, date and plac niner: On the basis of examination and/or investigation, in my opinion, death occ and manner stated.	

State Registrar

31. Date filed (Month Day, Year) 2004

DEVID NAHULEN

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

parks

10724 CATTLE DATUKBNT PARKING

29c. License number

0 36974

29d. Date signed (Month, Day, Year)

COLUMBIA

21544

1104

DHMH 17 Rev 1/2001

DAVIS, MILDRED

State of Maryland / Department of Health and Mental Hygiene 2004 12727 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year  $27\overline{}$ 5:32 P M BESSIE LEONA EBERSOLE MARCH 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death AVALON MANOR HEALTH CARE CENTER HAGERSTOWN WASHINGTON Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 6. Sex Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🖸 F Months Days Director 217-18-8286 87 MARCH 10, 1917 MARYLAND Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 ☑ No MARYLAND WASHINGTON HAGERSTOWN 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 14014 MARSH PIKE 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify 3 ☐ Widowed 4 ☑ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 ASSEMBLER AIRCRAFT MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fitteen of Health and Mental Hismt: If Item 27 Is marked other HARRY DANIEL BAKER ANNABELLE HAMMOND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JO ANN L. WEAVER/DAUGHTER 11807 GREENHILL DRIVE, HAGERSTOWN, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ROSE HILL CEMETERY 3/31/2004 HAGERSTOWN, MARYLAND 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Centro Varance Accident to mic /Medical Due to (or as a consequence of) **Examiner** regentin ソい Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760 attending physician Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ relevation Cerolio varan Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed; 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 2 1√10 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 Tyes 2 □ No after death | Director: / d in by the f 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 29. 2004 一ててんせ いいつ D(8019 5H5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VASANT DATER 21740 MILLET MAGERSTOWN MO 340 20 31. Date filed (Month Day, Year) MAR 30 32. Revistrar's Signature State Registrar

Louise M. Eschert -10-

			Please Type or Print in Black		-	_	
			. 101	epartment of Health and I Certificate of Death		giene Reg. No.2004	12728
	Physici /Medi		Decedent's Name (First, Middle, Last)     Mary Louise Eschert		2. Date of Dea Month		3. Time of Death
	Examir Funeral		4a. Facility Name (If not institution, give street and number)  MANOKIN MANOR  5. Social Security Number  6. Sex  7. Age (In yrs. last birt)	Months Days Hours Min	8. Date of Birth	4c. County of Death  Some  9. Birth  County of Death	Selface (State or Foreign Intry)
	Director		222-01-4448	rs.			yland  10d. Inside City Limits
	r 28e-f sho	Director	Delaware New Castle Newa	10f. Zip Code	1	10g. Citizen of What Cou	Y☐ Yes 2☐ No
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygiene. Item 27 is marked other than "netural", or Items 23e or 28e-f show other traumatic event, the Medical Exercinet must be notified at	by Funeral D	305 South Gerald Drive  11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	19713  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	USA  14. Race - Amer Black, White  Specify: Whi	, etc.
21215-0036	thin 72 hou e. an "netural Medical E	Completed	**	Decedent's Usual Occupation Give kind of work done during most of wor life. DO NOT use retired)	king	16b. Kind of Business/In	
ind 21	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, It e M	Be	11 Sec	cretary  18. Mother's Nam	ne (First, Middle, i	Manufactur Maiden Sumame)	ring
Maryland	d 2 should be f th and Mental I 7 is marked of traumatic eve	၉		Mailing Address (Street and Number or Ru			
Baltimore, I	Page nent o ant: If ury or		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of cemeter.  Salish	Somerset Avenue, Popisposition (Name of commatory or other place)  urv Crematory Apri.	Date	20c. Location - City or T	own, State
■ Bal	permit Pa Deparmer Important any injury once.		21. Signature of Fun-ral Service Licensee  22. Signature of Fun-ral Service Licensee  23a. Part 1. Enter the disease, or complications that caused the death. Do n	22. Name and Address of Facility Holloway Melson Fu 103 Linden Avenue, ot enter the mode of dving, such as cardiac	neral Ho Pocomok	ome Professi e City, Mar	onal Associ
68760,	Crate be executed by Sicilar and by Sicilar and by Sicilar and sthe burial-transit	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the condition of	Lyperte	Deses		Interval Between Onset and Death
O. Box	The law requires that the death certificate to the has been signed by the attending physic age? should be detached for use as the boage?	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv Month	ery Day Year
ords, P.	w requires that been signed t should be deta	by	Part II. Other significent conditions contributing to the ath but not resulting in	the underlying cause given in Part I.		bacco use contribute to t es 2 \$\overline{\ov	he cause of death?
Vital Records,		• Completed	Mellmonia 25. Was case referred to medical	On Place of Day		prior to co ned? death? 2 No 1 ☐ Yes	opsy findings available impletion of cause of
of Vil	Physicien: r this certific ral director,	To Be	examiner?  1 □ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Out	Other	th <i>Check onl on</i> ome 5 ☐ Reside	e ence 6 ∐Other <i>(Speci</i> i	(y)
Division o	tending Place Plac	Certification;	2 Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No		ow injury occurred	<b>10</b>
DİV	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		4 ☐ Homicide  determined  28e. Place of Injury - At home, far building, etc. (Specify)  29a. Certifier  1月 Certifying Physician: To the best of my knowledge,		City or Town		
	To the Hospitel within 24 hours. To the Funeral completely filled	Medical	(Check only 2 Medicel Exeminer: On the basis of examination and and manner stated.  29b. Signature and title pf certifier	or investigation, in my opinion, death occur	red at the time, da	ate and place, and due to	o the cause(s)
<i>S</i>	21.		30. Name any address of person who completed cause of death (Item 23a) (	(ype, Print) D 2950s	- 0	74-04-	04
	- 10 Sta		GREGORIO M. BELLOSO, M.D.; 530  31. Date (iled (Month Day, Year)  32. Registrar's Signature	2 CHINABERRY DRI	E, SALIS	BURY, OLD	21801
	Regist	rar	APR 0 7 2004 Singue &	Good			

		Registrar	te of Maryland / De	epartment of Health an Certificate of Death	Reg.	ne2004 12729
Physi /Med		1. Decedent's Name (First, Middle, Last) George F.	Emch		2. Date of Death Month Apr. 6, 20	Day Year 5:45 A M
Exam		4a. Facility Name (If not institution, give street a National Luther		4b. City, Town, or Location of D Rockville		4c. County of Death Montgomery
Funera Directo		5. Social Security Number 6. Sex 19 - 40 - 4102 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthd	Months   Days   Hours   8	Ain. (Month, Day, Ye	9. Birthplace (State or Foreign Country) 1925 Wash., DC
Maryland a-f show	tor	Usual Residence of Decedent  10a. State Montgome  Md. Montgome	ry 10c. City, Town or	r Location Silver Sprin	ā	10d. Inside City Limits  M☐ Yes 2☐ No
h with the 23a or 28 st be not	al Director	10e. Street and Number 14616- Peach Or	chard Rd.	10f. Zip Code 20905	10g.	Citizen of What Country? USA
Maryiand ZIZI3-UUSO d 2 should be tiled within 72 hours atter death with the Maryland th and Mental Hygiene. It is marked other than "netural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at	by Funeral	1 Never Married 217 Married 1	s Decedent Ever in U.S. ned Forces? Xves 2 □ No 'es, Give ar or DatesWW II	13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P 1 ☐ Yes 2 ☒ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
within 72 hours at ene. than "netural", or the Wadical Examine	Completed	15. Decedent's Education (Specify only highest grade comp.  Elementary/Secondary (0-12)  Co	llege (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of le. DO NOT use retired) hysicist	working	. Kind of Business/Industry
IZING A	To Be Co	17. Father's Name (First, Middle, Last) George Henry Em		18. Mother's	Name (First, Middle, Maid bel H. Stu	den Sumame)
		19a. Informant's Name/Relationship (Type, Pri Dorothy Emch— wif		ailing Address (Street and Number of 16-Peach Orcha		ver Spring, Md.
Cord. Pages 1 and Decretain Pages 1 and Decretain of Heal Important: If item 2 any injury or other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, c	sposition (Name of crematory or other place) s Church Cem. 4		Location - City or Town, State  Silver Spring, Md.
by 00,  ate be executed  Wedica  Examine  hysicien and the burial-transit	n al	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c.		ULAR ACCIDE	ac of respiratory arrest.	Approximate Interval Between Onset and Death
death certit	by Physician/Me	in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
Ords, F.O. requires that the een signed by the hould be detached.		Part II. Dther significant conditions contributing	ig to death but not resulting in the	e underlying cause given in Part I.		to use contribute to the cause of death?  2 2 No 3 7 Probably 4 7 Unknown
II RECOLUS, The law requires t cate has been signs, page 2 should be.	Completed				24a. Was an autopsy performed 1 □ Yes 2	
OI VITAL Physicien: ' r this certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital	1 ☐ Inpatient 2 ☐ ER/Outpa	Other	Death (Check only one) g Home 5  Residence	6 Mother (Specific)
nding Phy ath. r: After this e funeral d			Date of Injury (Month, Day Year) 28b. Time Injur	e of 28c. Injury at	28d. Describe how in	
DIVISION  lel or Attending s after death.  lel Director: After  ed in by the fune	Certification;	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerei Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examiner: Or	To the best of my knowledge, de the basis of examination and/or d manner stated.	eath occurred at the time, date and pl r investigation, in my opinion, death o	ace, and due to the cause courred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
T with To	Σ	29b. Signature and title of certifier  Where Queling	7.0	29c. License number		Date signed (Month, Day, Year)
(19)		30. Name and address of person who complete				H:0
	tate	31. Date filed (Month, Day, Year) APR 0 9 2004	32. Registrar's Signature		MANTOWN	1 1>
Regis	strar	MFR U 3 2004	Silver &	and a		)

			1 - For Stata Registrar	State of Marylan	d / Depa	artment <i>rtificate</i>	of H	ealth and Death	d Men		ene g. No. 2 0	004	12730
	Physici	an	1. Decedent's Name (First, Middle, Las.	,				-		ate of Death	Dav	Year	3. Time of Death
	/Medic		Alfredo	Escobar		1			A	ORIL		004	6:15PM
	Examir	ier	4a. Facility Name (If not institution, give Doctor's Commun	ity Hsopita		Ĺa	nha					,	George's
Н	Funeral Director		5. Social Security Number 6. Se 21 4 – 15 – 7840	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months	Days	If Under 24 H Hours M	in. (/	late of Birth Month, Day, 1		Cour	**
			Usual Residence of Decedent						8	/31/1	940		Salvador
	Marylar -f show lied at	tor	MD 10a. State 10b. County Prince		n, Town or Lo	ocation						1	0d. Inside City Limits 1 ☐ Yes 2X No
	h the or 28a s routi	irec	10e. Street and Number		<del></del>	10f. Zip (	Code			100	g. Citizen of	What Cour	ntry?
	23e c	raiD	8200 Goodluck R	oad		2	070	6			El	Salv	vador
36	within 72 hours after death with the Maryland ene. than "netural", or items 23e or 28e-f show he Medical Examinar must be reutified at	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decede If Yes, speci 1 Yes 2		spanic Origin? n, Mexican, Pu Specify:	(Specify serto Ricar	Yes or No- n, etc.)		ce - Americ ack, White, fy: Wh	
15-0(	be filed within 72 houral Hygiene. d other than "neture event, the Medical E	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usual kind of work DO NOT use	done d	uring most of t	working	16	6b. Kind of B	Business/In	dustry
212	filed with Hygiene. other that	Com	Elementary/Secondary (0-12) 12	College (1-4or 5+)	P	ackag	er				Froze	en Fo	oods
Maryland 21215-0036		To Be (	17. Father's Name (First, Middle, Last) Julio Rodrigue	Z				18. Mother's N		st, Middle, Ma Scoba		me)	
Mary	s 1 and 2 should I Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (7 Berta Rodrigue					nd Number or					
Baltimore,	Pages 1 and nent of Head		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	lace of Dispo emetery, crea ate o	matory or oth	ner place	2 4/0	Date 7 / 0 4		c. Location	-	own, State
Balti	permit. Pages Department of I Importent: If ite any injury or of		21. Signature of Futheral Service Light	/	p <sup>2</sup>	HILIF	Addres	RINAL	DI F	UNERA	L SEI	RVIC	E,P.A.
THE STREET	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a	25/S uence of):	ter the mode	of dying	j, such as card				pring	g , Md20910 Approximate Interval Between Onset and Death
8760,	cate be executed oblysician and the burial-transit	dicai Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ENCEPHI Due to (or as a consequence)  C. ENCEPHI  Due to (or as a consequence)  d. CEREISROV	9 LUF			こしのでん	( <del>, -</del>				
O. Box 6	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pre						ate of delive	ery Day Year
rds, P.	es tha igned be de	by	Part II. Other significant conditions or	ontributing to death but not resu	ulting in the u	nderlying ca	use give	n in Part I.			cco use con	tribute to th	ne cause of death?
Record	0 4 8	Completed							-	24a. Was an autopsy performe	ed2	prior to cor death?	psy findings available impletion of cause of
Vital	ilcien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					26. Place of [			)		
of V	Physicien: this certific ral director,	2	1 ☐ Yes 2 No		ER/Outpatier			4 14012111	g Home	5 🗌 Residen	ce 6 □Oth	her (Specify	()
Division o	ing After une	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Time o Injury	М		at ? ′es 2 □ No		Describe how			
Divi	ital or Attend irs after death rai Director; ,		4 Homicide determined	building, etc. (Specify	′) 					City or Town,	State)		l Route Number,
	To the Hospital within 24 hours of To the Funeral I completely filled	ledical	one) 2 Medical Exam	/sician: To the best of my kno iner: On the basis of examina- and marrner stated.	wledge, deat tion and/or in	vestigation,	in my op	inion, death o	ace, and d ccurred at	lue to the cau the time, date	ise(s) and m e and place,	anner as st and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			1		number			d. Date signe		
7	1		30. Name and address of person who	completed cause of death (Item 5 95 NGW //A	23a) (Type,	Print)	7	80	1 /	].H	PRIL	5,2	UU F
	1-1		ALEXANDER (Month, Day, Year)	33 PODITION 1/A	mpsH.	IRE /	NE	4310	LANC	SLEYT.	ARK,	110 0	109/2
	Sta Regist	ate i rar	APR 0 8 20	32. Registrar's Signa	G G	100	Beden	1					

			For State Registrar	State	of Maryla		artment rtificate				•	giene Reg. No. (	2004	12731
	Division		1. Decedent's Name (First, Midd	le, Last)		•					2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medio		Lillian		uller-Jo	ohnson					April	2	2004	4:55 P M
	Examir	er	4a. Facility Name (If not institutio		number)				Location			4c. C	ounty of Death	
			2607 Antler 5. Social Security Number	Court 6. Sex	7 Age (In yrs	s. last birthday)	If Under		er Sp		8. Date of Birt	h		omgery
	Funeral Director		579-40-1688	1 □ M 2 X F			Months	Days	Hours	Min.	Nov. 28	v. Y <i>ear</i> )	30 W	nplace (State or Foreign untry) ash., DC
T			Usual Residence of Decedent				11.					,	30	
relati	bo 🚆		10a. State 10b. County	/	10c. C	City, Town or Lo	cation							10d. Inside City Limits 1 XYes 2 No
W ec	98	Directo		lontgomer	у				er Sp	pring			1	
ti ti	e or 2	ā	10e. Street and Number				10f. Zip		0007				on of What Cou	•
eath,	18 23 19 19 19 19 19 19 19 19 19 19 19 19 19 1	Funeral	2607 Antler		ecedent Ever in	US 13	Was Deced		0904	igin? (Spe	acify Yes or No		. Rece - Amer	States
fter d	看	Fu	1 Never Married 2 Mar	ried Armed	Forces? s 2 <b>X</b> □No	-					ecify Yes or No- Rican, etc.)		Black, White	e, etc.
036	o, la	þ	3√ Widowed 4 Divorced	If Yes	Give r Dates:		1 ☐ Yes 2	2 L <u>X</u> No	Specify:			S	pecify: B	lack
Maryland 21215-0036 of 2 should be filed within 72 hours after death with the Maryland	age of the second	Completed	15. Deceder (Specify only highe	nt's Education	d)	(Give	dent's Usua kind of wor	rk done d	luring mos	t of worki	ing		of Business/l	
Z ig	han M	d d	Elementary/Secondary (0-12)		(1-4or 5+)		DO NOT us					_		tate & P.G.
בי קלים בי	lygie ther ti	ပိ	17. Father's Name (First, Middle,	( ast)		5	tate	& Co			Loyee			rd of Educ.
and	ed of	) Be	John Henr						TO. INIOUTE	or o realite	Rosa Et			1
<b>Y</b>	mark mark mati	၉	19a. Informant's Name/Relations	·		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	I Route Numbe			
<b>Z</b>	27 Is		Linda J. Full	ler - Dau	ghter	127	10 Te	aber	rv Ro	oad	Silver	Spri	ng. MD	20906-3365
altimore,	item item othe		20a. Method of Disposition		20b.	Place of Dispo	sition (Nam	ne of	-		ate		ition - City or 1	
mc	ant: If		1 XBurial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (\$		Ft	. Linco				4/8/2	2004	Br	entwood	i, MD
ترد <u>ه</u>	Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examble, must be notified at 200s.		21. Signalure of Funeral Service	Licensee	A m	- 22	2. Name and	d Addres	s of Facilit	ty St	ewart I	uner	al Home	2
ZX-2	10 E 2 3		John 1.	oull	M, 11.		4001	Benn	ing I	Rd.,	N.E. Wa	ish.,	DC 20	
			23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause o	at caused the dea n each line.	ath. Do not ent	er the mode	e of dying	, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
/	hysician		Immediate Cause (Final disease or condition resulting in death)		Pneumon									Sudden
	/Medical xaminer		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		to (or as a conse									
		e e	Sequentially list conditions, if any, leading to immediate	b. — Dua	Respira:	tory Fa	ilure							Sudden
uted	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>'</b>	Chronic	Obstru	ctive	Pu1	monai	r Di	sease			Years
8760, ate be executed	physician and s the burial-transit	EX	resulting in death) Last		to (or as a conse									
8760,	hysici the bu	Ilcai		d										
X O	attending pt	Physician/Medi	IF FEMALE:	02a Huaa										
Box	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	1 🗆 Liv	outcome of pregi e birth 2 □Fe egnant at time of	tal death 3	Ectopic pro					23	<ul> <li>Date of deliving</li> <li>Month</li> </ul>	very Day Year
P.O.	ed by the a	ysic	1 ∐ Yes 2 □ No 9 □ Unknown	9□Un		36	2 011101 (3)01	BCHy)						
_	igned b	y P	Part II. Other significant conditi	ions contributing to	death but not re	sulting in the u	nderlying ca	ause give	n in Part I		23e. Did to	bacco use	contribute to	the cause of death?
rds	n sign	ed by									1 □ Y	'es 2 🗀	No 3□Pro	bably 4 QUnknown
000	as been si 2 should	piet									24a. Was		24b. Were aut	opsy findings available ompletion of cause of
<u>~</u>	ate has page 2	Completed									autop perfor 1  Yes	med? 2X No	death?	
/ita	ertific ctor,	Be (	25. Was case referred to medica examiner?							of Death	(Check only o	ne)		
	this o	P	1 ☐ Yes 2 ☐XNo		□Inpatient 2[	-			4 🗀 140		me 5 🔀 Resid			ify)
on C	After funer	ion	27. Manner of Death 1 ☐Natural 5 ☐ Pendi		te of Injury onth, Day Year)	28b. Time o Injury	M 2	8c. Injury Work	at ? ∕es 2 🗍		28d. Describe h	ow injury o	occurred	
Division of Vital Records,	death ctor: / y the f	fical	3 ☐ Suicide 6 ☐ Could	not be nined 28e. Pla	ace of Injury - At	home, farm, sti				_			Number or Rur	ral Route Number,
<u>ה</u> ל	after Direct	Certification:	4  Homicide	bu bu	ilding, etc. (Spec	cify)	,				City or Tow	n, State)		
The Hospital	within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page			ng Physicien: To										
H ad	in 24 the Fu	ledical	one)		anner stated.	ation and/or in				in occurr				
Ę	within 2 To the	Σ	29b. Signature and title of certific	er	1.0		29c	. License			4		signed (Month,	
7	1	)	Joseph M	Ha 1	VI		5111		D-323	332		Ap	ril 6,	2004
			30. Name and address of persor Suresh K.					Ave	. Ste	e. 2-	·20, Sil	ver	Spring.	MD 20902
	Sta	ite	31. Date filed (Month, Day, Year	) 32	_egistrar's Sigi	nature			, 500		,			20,02
	Regist		APR 0 9	2004	Degree o	1 A	and)							

			For State Registrar	State	of Mar	yland	d / Depa <i>Cer</i>	ırtmen tificat	t of H e <i>of L</i>	ealth a Death	and M	lental Hy	giene Reg. No.	200	)4	12732
Phy	ysicia	ın	1. Decedent's Name (First, Middle, L									2. Date of De Month	Day		ear	3. Time of Death 9:20pm M
	ledic amin		Jeanette Friedma  4a. Facility Name (If not institution, g		number)			4b. City,	Town, or	Location of	of Death	April (	-	04 County of	Death	9.20pm
	A P	<b>6</b> 7).	Mariner Health					Beth			0411			ntgo		
Fun- Direc	_		5. Social Security Number 6. 061-01-1994	Sex 1 ☐ M 2XCF	=	in yrs. 18 01	ast birthday) Yrs.	If Under Months	Days	If Under: Hours	Min.	8. Date of Bir (Month, Da Feb. 24	y, Year)		Count	lace (State or Foreign try) York
g.			Usual Residence of Decedent  10a. State 10b. County				, Town or Lo	cation							10	Od. Inside City Limits
Maryla -f show	in the	to	Maryland Montgor	nerv		,	hesda	oution								1 ☐ Yes 2X No
th the or 28a	Book	Directo	10e. Street and Number	icly			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip	Code				10g. Citiz	en of Wha	at Count	try?
s 23a	d dan	eral	4925 Battery Lai		ecedent Eve	or in 11	S 13 V	208		snanic Ori	gin? (Sn	acify Yes or No		ted :		
after de	direct	Funeral	11. Marital Status  1 Never Married 2 Married	Armed 1 ☐ Ye	Forces? s 2  No	61 III O.C				n, Mexican	, Puerto	ecify Yes or No Rican, etc.)		Black,	White, e	
DESIGNATION E. INITIVISION A LATE 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28a-f show	Esta	d by	3 ₩ Widowed 4 Divorced		or Dates:									Specify: and of Busin	Whi	
6 13-	Nedis	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	rade complete	e (1-4or 5+)		16a. Deced (Give life. L	kind of wo	rk done d se retired	during mosi )	t of work	ing	160. KII	id of Busir	622/11/0	ustry
A I A	2	Com	12				Jewe1	Ler/O	wner					elry	Sto	re
ytaric buld be file Mental Hy arked oth	949	Be	17. Father's Name (First, Middle, La	it)								e (First, Middle)	, Maiden :	Sumame)		
should Me a mark	umatic	ပ္	UNKNOWN  19a. Informant's Name/Relationship	(Type, Print)			19b. Mailin	g Address	(Street a		NKNOV or or Rura	NIN al Route Numb	er, City or	Town, Sta	ıte, Zip	Code)
and 2 sh ealth and m 27 is n	ner tra			(Attorn	ey)	act B				Aven		202, Be				
ages 1 nt of H	or of		20a. Method of Disposition  1 Burial 2 XCremation 3		om State	CE	ace of Dispo emetery, cren	natory or o	ther plac	Ī		Dete		cation - Cit		
Dallinore, Demil. Pages 1 a Department of Hei mportent: If item	r injury		* 4 □ Donation 5 □ Other (Spe 21. Signature of Euneral Service Lice		34	Met		. Name an	d Addres	s of Facilit	y DeV	ol Fune	eral	Home		Virginia
	any ir		Votale II	Jefel										ersbu	ırg,	MD 20877
	*		23a. Part1. Enter the disease, or co shock or heart failure. List on Immediate Cause (Final	ly one caluse o	on each line.				e of dying	g, such as	cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death
Physic /Med			disease or condition resulting in death)		iratio		neumor	nia							-	
Exami	iner		Sequentially list conditions.	b. Con	gesti	ve C	Cardion	nyopa	thy							
ted	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a	consequ	ience ot):									
ate be executed hysician and	rial-tra		that initiated events resulting in death) Last	c	to (or as a	consequ	ience of):									
OS/OU ificate be e g physician	the bu	dical	•	d											+	
COIGS, P.O. BOX OB/OU, wrequires that the death certificate be executed been signed by the attending physician and	ISB as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		outcome of								2	3d. Date o	d delive	ry
death death	ad for i	iclar	in the past 12 months? 1 ☐ Yes 2 ☒ No	4□Pre	ve birth 2 egnant at tir nknown			Ectopic pr Other (sp						Month		Day Year
Ords, P.O requires that the een signed by th	Jetach		9 Unknown  Part II. Other significant conditions	_		not resu	ulting in the u	nderlying	ause give	en in Part I		23e. Did t	obacco u	se contribu	ite to th	e cause of death?
COLOS, w requires t	ed bl	d by										10	Yes 2	No 3[	_ Proba	ably 4 Unknown
es co co	CV	Completed										24a. Was		24b. Wei	e autor	osy findings available inpletion of cause of
ate Th	pag	Сош										perfo 1 ☐ Yes	rmed?	dea	th?	2 No
OT VICEL P Physician: Th rthis certificate		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2X No	Hospital:	☐Inpatient	2 🗆	ER/Outpatien	* 3 \( \)	Othe			n <i>(Check only o</i> me 5 ☐ Resi		. □Other /	Spacifu	
	neral d	-	27. Manner of Death		ate of Injury		28b. Time of		28c. injury Work			28d. Describe			Specify,	/
UIVISION I or Attending after death. Director: After	by the funeral o	Certification:	1X\( \text{Natural} \) 5 \( \text{Pending} \) 2 \( \text{Accident} \) 3 \( \text{Suicide} \) 6 \( \text{Could no} \)	ion				М	1 🗆 '	Yes 2□	No	OOK Lacation (	Chronet and	d a leasan and	C.	D- 40 Number
		ertifl	4 Homicide determine	A 200. PR	uilding, etc.	/ - At no (Specify	me, farm, str ')	eet, factor	y, office			City or To			ir murai	l Route Number,
Hospita 4 hours Funere	elly fille	edical C	29a. Certifier 1 🔀 Certifying (Check only one)	eminer: On the		xaminat										
To the I within 2.	сошрі	Me	29b. Signature and title of certifier			o <sub>b</sub>	4. 5			number				1 1		Day, Year)
8			Alpara	lyon		7	M.D		1 -	27	560		4	15/	04	
S			30. Name and addless of person was Alpana Goswami,	/					g100	, Roc	kvi1	1e, MD	2085	2		
20	Sta		31. Date filed (Month, Day, Year)		2. Registrar'			lo	ca de	,						

			1 - State Registrar	te of Marylar		artment of H tificate of L			giene Reg. No. 2 (	206	12733
1955;	Physicia		Decedent's Name (First, Middle, Last)     Rosemary (	. Fluri				2. Date of Dea Month April		2Ŏö́4	3. time of Death 8:00 P M
	/Medic Examin	4.	4a. Facility Name (If not institution, give street a			4b. City, Town, or	Location of De		4c. County		0.00 1
		<i>A</i>	Stella Maris				eysville		Balt	timore	
	Funeral Director		5. Social Security Number 6. Sex 171 24 1692	7. Age (In yrs. 74	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		v. Year)	9. Birthpl Count Penr	ace (State or Foreign try) nsylvania
death with the Maryland	f show	Jo.	Usual Residence of Decedent  10a. State  10b. County  MD  Howard		y, Town or Lo					10	0d. Inside City Limits 1 ☐ Yes 2 No
the !	r 28a-	irec	MD Howard  10e. Street and Number	<u> </u>	TICOLL	10f. Zip Code			10g. Citizen of	What Count	try?
th wit	23a o	aiD	5513 Aspen Dale Court			2104	3		United	d Stat	ces
OUSO hours after dea	if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f ehow other treumatic event, I've Medical Exertal erround be invitited at	by Funeral Director	1 Never Married 2 Marned 1 If Y	s Decedent Ever in U ed Forces? Yes 2X No es, Give er or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 □No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- lerto Rican, etc.)	14. Rad Blad Specify	ce - America ck, White, e	
d ZIZIJ-0030 filed within 72 hours after	e. en "nature Medicul E	Completed		ege (1-4or 5+)	(Give life. I	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of v	working	16b. Kind of B	usiness/Ind	
N Del	her th	Con	17. Father's Name (First, Middle, Last)		Hom	emaker	19 Mothor's h	Name (First, Middle,	Own I		
arytand should be fil	Mental F parked of patic ever	To Be	Nicholas Callen				Sarah 1	<u> Tempest</u>			
Mar nd 2 sh	tth and 27 is n r treun		19a. Informant's Name/Relationship (Type, Prin Gene J. Fluri/Husband	17)				Rural Route Numbe			
nore,	ant of Health a it: If item 27 is y or othar treu		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	HOIH State	Place of Dispo cemetery, crem	sition (Name of natory or other place	e)	Date -12-2004	20c. Location -	City or Tov	wn, State
Daitimor	Department of Healimportant: If item 2 eny injury or other		21. Signature of Funeral Service Licensee	M010	44 22	. Name and Addres	s of FacilityHa		tzke's	Famil	y FH Inc.
	ıysician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	that caused the deate on each line.	h. Do not ent	er the mode of dying					Approximate Interval Between Onset and Death
	Medical caminer	J.	Sequentially list conditions. b	ue to or as a conseque to or as a conseque					-		
ate be executed	ohysician and the burial-transit	icai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	ue to (or as a conseq							
I RECOLUS, P.O. BOX 00/00, The law requires that the death certificate be executed	been signed by the attending ph should be detached for use as t	Physician/Med	in the past 12 months?	es, outcome of pregna Live birth 2  Feta Pregnant at time of d Unknown	ıldeath 3⊑	Ectopic pregnancy Other (specify)				te of deliver	y Day Year
w requires that	n signed b Ild be deta	þ	Part II. Other significant conditions contributing	g to death but not res	ulting in the ur	nderlying cause give	en in Part I.	11	bacco use cont es 2 □ No		cause of death?
The law rec	ate has bee page 2 shor	Completed						24a. Was a autops perfor	sy med?	prior to com d <u>ea</u> th?	sy findings available pletion of cause of
Or VICAL Physicien:	his certifical director,	To Be C	25. Was case referred to medical examiner?  1 \( \subseteq Yes \) 2 \( \supseteq No \)  Hospital	1  Inpatient 2	ER/Outpatien	t 3 DOA Othe	NC.	Death (Check only or Home 5 Resident	ne)	er (Specify)	HOSPICE
VISION C	within 24 hours after death.  To the Funerel Diractor: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation	Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ?? ∕es 2 □ No	28d. Describe h			
itel or Att	rs after d rel Diract led in by I		4 Homicide determined 286.	Place of Injury · At h- building, etc. (Specil	(y)			28f. Location (S. City or Town	n, State)		
he Hosp	in 24 hou he Fune bietely fil	Medicai	29a. Certifier (Check only one)  1 Certifying Physician: 2 Medical Examiner: Or an	To the best of my kno the basis of examina i manner stated.	owledge, death	occurred at the tim restigation, in my op	e, date and pla pinion, death oc	ace, and due to the c courred at the time, d	ause(s) and ma late and place, a	anner as sta and due to t	ted. the cause(s)
Tot	Tot	≥	29b. Signature and title of certifier			29c. License			9d. Date signed		
~ ^	2		20. Name and address of passes who severiles	d cause of death flear	n 22a) /T	400	3725		April	9, 20	004
0	,		30. Name and address of person who complete	L cause of death (iter	п 23a) (тур <del>в</del> ,	TIME ROLL	ELMONTE	M MD 21	093		
30. 45.5	Sta Registr		31. Date filed (Month, Day, Year)  APR 0 9 2004	32. Registrar's Signa	ature	0					

Ctate of Mondand / Denov	tennet of Lipskib and Man	at Hygiana 2 11 11
State of Maryland / Depar	tinent of health and Men	ai riyyieneZ U U i

			. For	State of Maryla	nd / Depa	artment of He	eaith and M	ental Hyg	iene2004	12734
			1 - State Registrar		Cei	tificate of D	eath		g. No.	
	Physici	an	1. Decedent's Name (First, Middle, La	Freeman	^			2. Date of Deat	Day Yeer	3. Time of Death 4 5233 PM
	/Medio	al er	4a. Facility Name (If not institution, given Howard County Ge.			4b. City, Town, or L	ocation of Death	April	4c. County of Dea	
The second	<i>3</i> ,	<u> </u>				Columbia			Howard	
Е	Funeral Director		5. Social Security Number 6. S 284-30-1491	ex X□M 2□F 75	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 10/29/1	Yeer) 9. Bir 928 Was	thplace (State or Foreign ountry) hinton DC
- 18	D .		Usual Residence of Decedent  10a, State 10b. County	10c (	City, Town or Lo	cation		10/25/ 2	7.74.5	10d. Inside City Limits
	Maryli -f eho	tor	MD 10b. County Howard		olumbia					1 ☐ Yes 2X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show sny injury or other traumatic event, the Medical Examinar must be notified at ODGe.	Funeral Director	10e. Street and Number 5086 Durham Road	West		10f. Zip Code 21044		11	og. Citizen of What Co USA	ountry?
	ams 2	Inera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
036	urs afte el', or it Examin	۾	t ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	M Yes 2 No It Yes, Give Year or Dates:		1 ☐ Yes 🎾 No	Specify:		Specify: Bl	
21215-0036	n 72 ho	Completed	15. Decedent's E (Specify only highest gra		(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of worki	ng	16b. Kind of Business	/Industry
212	yiene.	ошо	Elementary/Secondary (0-12)	College (1-4or 5+) 4+		al Educati	on Teach	er	DC Publi	c Schools
p	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Last,			1	8. Mother's Name	(First, Middle, A		
Maryland	d Meni d Meni narke	ပ္	Charles W. Freem.  19a. Informant's Name/Relationship (		10h Mailie		Mable Jo		City or Town, State,	Zin Codo l
	nd 2 st alth and 27 is r r traur		Bette C. Freeman						a, MD 2104	
Baltimore,	of Head		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3 □		Place of Dispo cemetery, cres	sition (Name of natory or other place)			20c. Location - City or	
Ħ H	it. Pag rtment rtant: njury o		* 4 □ Donation 5 □ Other (Special 21. Sign turn of Funeral Service ∠cq.	y) Me	etro Cro		4/8/2		atonsville zke's Fam	
Ba	Depa Impo eny ii		mare P	Imato					ott City,	
		s I	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.			11.191	100	*	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ARTERI Due to (or as a conse		EROTIC	andiova	scular	Disease	Years
	Examiner		Sequentially list conditions	b.	equence ory.					1720
	bed nsit	nlner	Sequentially list conditions, narry, reacting to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of).					
oʻ	te be executed ysician and e burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
8760,		dical		d						
89 xo	n centiti nding i use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg				- 111-111000	23d. Date of de	livery
P.O. Box	The law requires that the death certilica ste has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
S, D	res that igned b be deta	by Pł	Part II. Other significant conditions	2 10	esulting in the u	nderlying cause given	in Part I.	23e. Did tob	acco use contribute to	
ord	w requir been si should	eted	Diabetes	Mellitus				1 🗆 Ye		obably 4 Unknown
Vital Records,	he law e has l	Completed						24a. Was ar autopsy perform	ned? prior to death?	utopsy findings available completion of cause of
ita	ician: The certificate rector, pag	0	25. Was case referred to medical		nieng		26. Place of Death		ZNo 1 ☐ Yes	2□ No
<u>×</u>	Physician: r this certificaral director.	ToB	examiner?		ER/Outpatien		4 Nursing Hon	ne 5 🗆 Reside	nce 6 Other (Spe	city)
ouo	ding P h. Alter t funera	tion:	27. Manner of Death  1 Matural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	Work?	at 2 os 2 ⊡ No	28d. Describe ho	w injury occurred	
Division of	l or Attending atter death. Director: Altel in by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined		home, farm, str cify)		120	28f. Location (Str City or Town	eet and Number or Ri State)	ural Route Number,
	To the Hospitel or Attending Physician: The within 24 Hours after death.  To the Funeral Director: Alter this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Pr (Check only one)	ysician: To the best of my kininer: On the basis of examinand manner stated.	nowledge, death	occurred at the time restigation, in my opin	, date and place, a nion, death occurre	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License r	number	29	d. Date signed (Mont	h, Dey, Year)
	3		Bert 7. V	Torton m	1.D.	1080	149	F	toril 7, a	2004
0	)&		30. Name and address of person who Bert F. Mov	completed cause of death (It	em 23a) (Туре, _ Man		rive :	E.llico	Et City. M	(1) 21043
	Sta		31. Date filed (Month, Day, Year)	32. egistrar's Sig	nature	racks	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				For State Registrar	State of Maryland / [	Department of F Certificate of		ental Hygie	2001	12735
		Physici		1. Decedent's Name (First, Middle, Last) KATHERINE S.	FIZER	-		2. Date of Death	Day Year	3. Time of Death
		/Medic Examin		4a. Facility Name (If not institution, give s  Citizens Nursi  5. Social Security Number 6. Sex	ng Home	Havre	r Location of Death  Compared to the compared	ace 8. Date of Birth 12/18/191	4c. County of Deal	tholage (State or Foreign
		Director		213-30-8529 1 Usual Residence of Decedent	M 3€7 90	Yrs. Mollins Days	Hours Min.	127187191	73 Penir	sylvania
		Aaryland I show	ō	10a. State 10b. County MD Harford	10c. City, Tow Hav	n or Location re de Grac	e			10d. Inside City Limits 1 ☐ Yes 2X No
		3s or 28e-	al Director	10e. Street and Number 4212 Kevin Road		10f. Zip Code 2107	8	10g.	Citizen of What Co USA	puntry?
	980	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or ttems 23a or 28e-f show ent, the Madical Examir er must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 🏋 Widowed 4 □ Divorced	I2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1  Yes 2 X No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
	Baltimore, Maryland 21215-0036	within 72 ho ane. Ihen "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of worki	ng	Rentals	Industry
	land 2	is 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other then other treumatic event, the M.	To Be Co	17. Father's Name (First, Middle, Last) Andrew Urey		Manager		(First, Middle, Maile e Tome	den Sumame)	
	Mary	in 1 and 2 shou Health and M tem 27 is mail		19a Informant's Name/Relationship (Ty) Elsie Dougan	00, Print) 19b	. Mailing Address (Street 12 Kevin Roa			•	
	imore,	Page ment c ant: If ury or		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State Slatev	t Disposition (Name of ry, crematory or other place ille Cemeter	ce)		Location - City or ⊇1ta, PA	Town, State
	Balt	permit. Departr Imports any inji		21. Signatur of Funeral Service Licens	Fareledo	22. Name and Addre		c.,600 Main	St.,Delta,	PA 17314
•		Pnysician /Medical		233 art1. Infer the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	APPS VI	sg, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
光	18760,	icate be executed by physician and burial-transit or	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Decade of Figury that initiated events resulting in death) Last	Due to (or as a consequence					
	Вох 6	certifi anding use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify) _	,		23d. Date of deli Month	ivery Day Year
\	ds, P.O.	w requires that the death been signed by the atte should be detached for	Ď	Part II. Other significant conditions con	tributing to death but not resulting i	n the underlying cause giv	en in Part I.			the cause of death?
atherine	Division of Vital Records,	The law requate has been page 2 should	completed					24a. Was an autopsy performeg 1 ☐ Yes 2 ☑	prior to death?	topsy findings available completion of cause of
ne	Vita	ysician: The la iis certificate had director, page 2	o Be C	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3□ DOA Oth	26. Place of Death	(Check only one)	C COther (See	aif d
Kat	ion of	To the Hospitel or Attanding Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	<del> </del>	27. Man er of Death  1 Vatural  2 Accident investigation	28a. Date of Injury 28b.	Time of 28c. Injury Wor	100	8d. Describe how i		any)
128F	Divis	el or Atts s after des el Director ed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	2	8f. Location (Stree City or Town, S	t a <i>nd Number</i> or Ru tate)	ral Route Number,
17		e Hospit 124 hours e Funere letely fille	edicai (	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my knowledge ner: On the basis of examination an and manner stated.	e, death occurred at the tind d/or investigation, in my o	ne, date and place, a pinion, death occurre	and due to the cause and at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	)	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. Licens	6H2	29d.	Date spined (Mont)	n, Day, Year)
	342	2		4. Sup Gim	mpleted cause of death (Item 23a)	(Type, Print) WILLS	n kw	MA	· mp	21678
	H	Sta Registi		31. Date filed (Month, Day, Year) APR - 8 2	32. Registrar's Signature					·

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Mar	•	artment of rtificate of				giene <sub>Reg. No</sub> 2	004	127	136
	Physici	an	Decedent's Name (First, Middle, Last)  THE ODODE	MTLLADD	FURNITOR			:	2. Date of Dea Month	th Day	04 <sup>ear</sup>	3. Time of	
Ì	/Medic Examir	cal	THEODORE  4a. Fecility Name (If not institution, give s 604 MONROE ST		FURNISS	4b. City, Town, SAL ISBU		of Death		4c. C	ounty of Death		Дм
	Funeral Director		220 72 1277	7. Age (	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth Month, Day 12-21	year)	9. Birth Phi	place (State ontry) A. Pa.	
	he Maryland 28a-f show otified at	Director	Usual Residence of Decedent   10a. State   10b. County	1	SALISBUR	RY				10- 6			ity Limits
	3a or 2	i Dir	10e. Street and Number 604 MONROE STR	EET		10f. Zip Code 218	03			_	en of What Cou USA	ntry?	
980	filed within 72 hours after death with the Maryland Hygiene ther than "natural", or Items 23a or 28a-f show ther than "natural", or Items 23a or 28a-f show ant, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1/∑Yes 2 □ No If Yes, Give Year or Dates:	er in U.S. 13. IREAN	Was Decedent of If Yes, specify Cul			cify Yes or No- Rican, etc.)		Black, White,		RICAN
Maryland 21215-0036	within 72 ho jene. r than "naturi the Medical i	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most	t of workir	99		of Business/In		
/land ?	should be filed and Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) HARRY JAC	KSON FURNI	SS		18. Mothe		(First, Middle, QUEEN E		umame) BE <b>TH</b> PA	RSON	
	t and 2 Health a em 27 ls ther trei		19a. Informant's Name/Relationship (Ty,  JOANN FURNISS/ WII  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R	FE	604 20b. Place of Dispo	ng Address (Stree MONROE S sition (Name of matory or other pla	TREET:	SAL		MD.			
Baltimore,	permit. Pages Department of I Importent: If it any injury or o 2002e.		'4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	MAUSOLEUM	SPRINGHI 25	LL MEMOR 2. Name and Addr 1213 JER	ess of Facilit			10RIA	ON, MD. L CHAPE MD. 21	L	
	Physician and // // // // // // // // // // // // //	ai Examiner	23a. Part1 Enter the disease, or complete shock, or heart failure. List only and lisease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a o	consequence of):	er the mode of dy	nell	14	4		~ . 11/3e	Approximat Interval Bet Onset and I	tween Death
.O. Box 687	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify)	ey .			23	d. Date of delive	*	Year
ds, P.(	juires that the signed by ald be detact	Ď	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause g	ven in Part I.			bacco use	contribute to the		death? Unknown
al Reco	iician: The law requird certificate has been si rector, page 2 should I	Completed							24a. Was a autope perfor	sy	24b. Were auto prior to co death? 1 □ Yes	mpletion of ca	available ause of
Division of Vital Records,	ding Phys h. After this funeral di	ation: To Be	25. Was case referred to medical examiner?  1 Yes 20 No  1 Natural 5 Pending investigation	lospital: 1 Inpatient 28a. Date of Injury (Month, Day )	2 ER/Outpatier 28b. Time o	f 28c. Inju	her: 4 🗆 Nu	rsing Hom 2	(Check only or te 5 X Reside 8d. Discribe h	ence 6[	Other (Specificoccurred	у)	
Divis	al or Attends after death of Director: , al Director: , ad in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, sta (Specify)	reet, factory, office		2	8f. Location (S City or Town		Number or Rura	I Route Num	ber,
	To the Hospital within 24 hours of To the Funeral I completely filled	edicai	(Check only 2 Medicel Examir one)	sician: To the best of ener: On the basis of ener and manner state	xamination and/or in	vestigation, in my	opinion, deat	d place, a th occurre	d at the time, d	ate and pl	ace, and due to	the cause(s	·)
	To the within: To the comple	M	29b. Signature and title of contitor	4	)	29c. Licen	305	41	9	9d. Date s	30 o	Day, Year)	
V			30. Name and address of person who co	32. Registrar	th (Item 23a) (Type,	$m_{1}$		ford	St. Sa	lisb	ury Md	21801	
	Sta Regist			)04 32. Hegistrar	Signature /	Spor	(s)						

			1 - For State Registrar	State of Ma	aryland / Depa	artment o	of Health an of Death	d Mental Hy	giene 20	04 12737
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Cynthia Irene Gan					2. Date of De Month March		3. Time of Death 08:20 A M
	Examir	ner	4a. Fecility Name (If not institution, give s 11 S. Walnut Stree	t		Hager			4c. County of Wash	ngton
- 4	Funeral Director		5. Social Security Number 219-66-1330 6. Sex	7. Age	(In yrs. last birthday) 47 Yrs.	If Under 1 You Months Da	ear If Under 24 I ays Hours N	Hrs. 8. Date of Bir (Month, Da 02/08/	th y, Year) 1957	Birthplace (State or Foreign Country)     MD
	Maryland	tor	10a. State 10b. County MD Washingto	n	10c. City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 3a or 28a st be roti	al Direc	10e. Street and Number 11 S. Walnut Street		nagezbeor	10f. Zip Cod			10g. Citizen of W	hat Country?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Exc. circle rest be routified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	2. Was Decedent E Amed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	lo		of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	- 14. Rece	- American Indian, , White, etc. White
Maryland 21215-0036	l within 72 ho jiene. r than "natur The Wedleal	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5	(Give	dent's Usual Ockind of work do	one during most of tired)	working	16b. Kind of Bus	
yland;	should be filed and Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Richard Glenn Lady				18. Mother's Nancy	Name <i>(First, Middle,</i> 7 Jo Leckr	Maiden Sumame	)
	es 1 and 2 si of Health and f Item 27 is r r other traur		19a. Informant's Name/Relationship (Type Walter Humbertson/ 20a. Method of Disposition	Brother		Nesbi	tt Avenue	Rural Route Number, Clear S	pring, M	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		1 □ Burial 2 ②Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Smithsbur	g Crema . Name and Ad	ator. 03/		Minnich	rg, MD Funeral Home , MD 21740
	Physician		23a. Part1. Enter the diséase, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each in	the death. Do not ente					Approximate Interval Between Onset and Death
E	/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):	rocad		nction		homa y
٥	certificate be executed nding physicien and use as the burial-transit	lical	resulting in death) Last  d.		consequence of);					
P.O. Box	the death by the atter ached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnal Other (specify)			23d. Date Month	•
ecords, r	res ti	þ	Part II. Other significant conditions cont	ributing to death but	t not resulting in the un	derlying cause	given in Part I.			ute to the cause of death?
r	The law ate has b page 2 st	e Completed	25. Was case referred to medical					24a. Was a autops perform	med? prid	re autopsy findings available or to completion of cause of ath? I Yes 2 \(\sum \text{No}\)
0	Phys this al dia	To B	examiner?  1  Yes 2 No Ho  27. Manner of Death  1  Actival 5 Pending  2  Accident investigation	spital: 1		28c. In W	Other: 4 Nursing	Home 5 A Peside 28d. Describe ho		(Specify)
DIVIS	ral or Atter sa after de al Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	et, factory, offic	СӨ	281. Location (St City or Town	reet and Number n, State)	or Rural Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	one)	cian: To the best of or: On the basis of e and manner state	my knowledge, death examination and/or invested.	estigation, in my	y opinion, death oc	ce, and due to the ca curred at the time, d	ause(s) and mann ate and place, and	er as stated. If due to the cause(s)
	2 1 × 2	_	29b. Signature and title of certifier			DI	8 0 1 9		9d. Date signed (I	Month, Day, Year)
9	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		30. Name and address of person who com  VA SANT DATT  31. Date filed (Month, Day, Year)	A MD	340 M		e mas	ers tow	n m	0 21740
	Stat Registra		MAR 29 200	32. Registrar	J. A.	arter				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11:20A M 23 March 2004 Gerald David Gross /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington 7543 McClellan Avenue Boonsboro If Under 1 Year | If Under 24 Hrs. 8. Date of Birth OCT-8, 1930 9. Birthplece (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 73 Yrs 218-24-9530 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Boonsboro Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7543 McClellan Avenue 21713 USA or Items 23e death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "netural", or Itel 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Engineer Aircraft Manufacturer of Health and Mental Hygie if item 27 is marked other in or other treumatic event, it 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ို Howard David Gross <u>Bessie Katherine Hudson</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 7543 McClellan Avenue Boonsboro, Maryland 21713 May V. Gross - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition

1 ★ Burial 2 □ Cremation 3 □ Removal from State Date permit. Pages 1 Department of H Important; If its eny injury or ott \* 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park Mar.26,2004 Hagerstown, Maryland 21. Signature of Funeral Service Licensee OSBOTHE TUNEFATINHOME, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TATIC ONEY EAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of). Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed BCTRUANT PILLMONARU OIS MASK 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 1 ☐ Yes 2 ☐ No certificate EKTUK KFURHACKE 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: J 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, offica building, etc. (Specify) 4 - Homicide within 24 hours at Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D40622 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMOR VIEW OR HABBER TOWN MO UETCAN mo 19236

Registrar

State

31. Date liled (Month, Day, Year)

MAR 2 4 2004

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32. Registrar's Signature

Mesercas

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 5.30pm 2004 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince Georges Heartland Health Care Center-Adelphi Adelphi If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Securify Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months 1□M 2√2F 88 Director 579-22-3722 9/18/15 Washington, D.C Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with tha Manyland tent of Haatth and Mantal Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 1 ☐ Yes 2 ☐ No D.C. Director Washington 7 is marked other than "natural", or items 23s or 28s-f traumatic event, the Medical Examinar must be notifie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4441 A Street, U.S.A.

14. Race - American Indian,
Black, White, atc. Funerai S.E. 20019 12. Was Decedenf Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Tes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) nd Mantal Hygiene. marked other than 10th Clerk Typist/Dept. of Agric. U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter W. Green <u>Mazzie E. Ennis</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Haatth of Hearth of Hea Jacqueline Green Smith/Niece 3843 Holloway Cir., Upper Marlboro Md. 20772 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: if It any injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Mem. Park 4/13/04 Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
H.S. Washington & Sons Co., Tr.C.
4925 Burroughs Ave., N.E., wash., D.C. 20019 21. Signature of Funeral Service Licensee Natt any W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) prelimaria /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner sician and bunat-transit Hospital or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician s the bunal Due to (or as a consequence of) attending for usa as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementia - Advanced. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s cartificate has the 1 ☐ Yes 2 ☑ No diractor, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No this : After this a funaral o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 □ Accident 5 Pending 1 Yes 2 No death. s after death.

i Director: Ai

od in by tha fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completaly filled edical Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suhitha Bhogavileiny, 1220 A East Joppa Road, Seit 236 Jowson, ND 21286 31. Date filed (Month, Day, Year)
APR 0 9 2004 Registrar's Signature State Registrar

DHMH 16 Rev 6/95

				State of M	landand	d / Dena	artment of H	lealth and	Mental Hyg	iene	9.2.0.		
		-	For State Registrar	State of W	iai yiai k		rtificate of			eg. No.2	001	127	LI
			Decedent's Name (First, Middentification)	fle, Last)					2. Date of Deat Month		Yeer	3. Time of	Death
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	Examin	_	4e. Facility Name (If not institution				11 11	r Location of Deat	th		unty of Deeth		
			Montgomery Ge 5. Social Security Number		a⊥ ge (In yrs. Ia	ast hirthday)	Rockvi	LLE If Under 24 Hrs	8. Dete of Birth		ontgome 9. Birthi	place (State o	r Foreian
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	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-f ehow he Mydigal Execitien must be notified at	급	2833 Lemar St	reet			20904			U.S		, .	
	death ms 23	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.	S, 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No-	14.	Race - Ameri Black, White,		
9	or Ite	Fur	1 ☐ Never Mamed 2 ☐ Ma	If Yes Give	No t	o	1 ☐ Yes 2 ☒ No		to Filoali, etc.)	Sc	pecify: Whi		
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b	other	BeC	17. Father's Name (First, Middle	, Last)				18. Mother's Na	me (First, Middle, I	Meiden Su	mame)		
/lar	Menta Menta Irked	ToE	Charles Rayn					Harrie					
Maryland	2 sho		19a. Informant's Name/Relation						ural Route Number				
e,	1 and 1 and 16aith 10 an 27 ther t		Dorothy Grier	Rich/Daught	20b. P	lace of Dispo	sition (Name of		Colonial		tion - City or T		
Ö	ni of it		1 ☐ Burial 2 ☑ Cremation		<u> </u>	emetery, cre	matory or other plac		/06/2004				and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel; or items 23s or 28s-f show mary injury or other traumatic event, the Medical Examinar must be notified at ODGs.		* 4 □ Donation 5 □ Other and Service 21. Signature of Funeral Service		FUL			The second second	RAL HOME,				904
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89	eath certificat attending phy for use as th	Completed by Physician/Med	IF FEMALE:								1		
Вох	attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fetal	death 3	□Ectopic pregnanc	y		230	<ol> <li>Date of deliving</li> <li>Month</li> </ol>	,	Year
	the death y the atter sched for u	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□ Unknown		eam 5	Other (specify) _						
P.0	res that the di signed by the be detached	y Ph	Part II. Other significant condi	tions contributing to death	but not resi	ulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	bacco use	contribute to t	the cause of d	leath?
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on C	ding F	ion	27. Manner of Death	28a. Date of in (Month, L stigation	Day Year)	28b. Time of Injury	Wo	rk?  Yes 2 □No	28d. Describe h	OW HIJUTY C	ccurred		
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<u>S</u>	after after Dire d in b	Certification:	4 Homicide	building,	etc. (Specif	y)			City or Town	n, State)			
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	Dogiat	201	ADD A	* FEDERAL TOTAL			KIRIVERUS						

	1- State of Maryland / Department	artment of Health and Martificate of Death	ental Hygiene 200	4 12741
	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Physician /Medical	Lyle W. Gundy		April 6, 2004	10:30 P M
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of D	
	Suburban Hospital	Bethesda	Montgome	rv
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9, E	Birthplace (State or Foreign
Director	577-16-0224	Months Days Hours Min.	Nov. 24, 1912 In	Country) diana
2	Usual Residence of Decedent			
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or 28	10e. Street and Number	10f. Zip Code	10g. Citizen of What	Country?
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dea	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- 14. Race - Ar	merican Indian,
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hydiene. Important: If Item 27 is marked other than "natural", or any injury gether traumatic event, the Medical Exercitions.  To Be Completed by F	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Sumame)	
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30 pM  3altimore emit. Pages 1: epartment of He mportant: If Iten ny injury greth ince.	20a. Method of Disposition 20b. Place of Disposition 1 🛣 Burial 2 🗆 Cremation 3 🗀 Removal from State	sition (Name of natory or other place) Memorial April	10,	or Town, State
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Ψ/6/β β β SB760, licate be executed physician and sine burial-transit	Cause (Disease or injury that initiated events Cerebrovascular Ac	ccident		
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the mple	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d Date signed (Me)	nth Day Voorl
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5	Tellal N X bellstein	D03581	April 7,	2004
	30. Name and address of person who impleted cause of death (Item 23a) (Type,	•		
	Elliot R. Goldstein, M.D. 6000 Executi	ve Blvd. #300, Roc	kville, Maryland	1 20852
State Registrar	31. Date filed (Month, Day, Year)  APR 0 9 2004  32. Registrar's Signature	Sporker		

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I	_			Gibbs								2. Date of D Month March	Da	, 2004	ear	3. Time of Death 7:40 P M
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Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or  10a. Street and Number  10a. Street and Number  10a. Street and Number  10a. Street and Number  10a. Street and Number  10a. Street and Number  10a. Street and Number  10a. Street and Number  10a. Street and Number  10a. Street and Number  10a. Street and Number  11. Marital Status  1   Never Married 2   Married   Marrie								If Under 1		7111e	24 Hrs.	8. Date of Bi	rth	Montg 9.		y ice (State or Foreign
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	yland now					10c. Cit	ry, Town or Lo	cation							10	d. Inside City Limits
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	with th	Dire	10e. Street and Number					10f. Zip (	Code				10g. Ci	tizen of Wha	t Countr	y?
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9	after d	Fun		Married	Armed Fo	orces? 2 □ No WO1	-Tq				, Puerto	ecify Yes or N Rican, etc.)		Black, V		
003	iours a	d by	21		Year or D			1 □ Yes 2		Specify:				Specity:	Whi	
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12	l withii iene. r than	ошо	Elementary/Secondary (0	·12)		1-4or 5+)		gist/			Advo	cate	Edu	ıcatio	n	
	al Hyg I otha vant,		17. Father's Name (First, M.	ddle, Last	)					18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)		
yla	ould b Ment harked	2										Bostwi				
Mar	d 2 sh th and 7 is rr traum					r						l Route Numb		,	, ,	
	f Heall tam 2		20a. Method of Disposition			20b. F					priÎ			ocation - City		0850 n, State
E O	Page nent of a mit if if					State Mor	itgomer ematori	y iim. T	nc.		2004		Bet	hesda	. Ma	ryland
alti	epartm spartm sports y inju		21. Signature of Funeral Se	rvice Licer	1	102	22	2. Name and	Addres	s of Facilit	y Rob	ert A.	Pum	ohrev	Fune	eral Home/
_	89 E 2 9	- 11	Mai	یح.	(eu	-						West 1 2085		)5	AVE	enue
			shock, or heart failure	se, or com . List only	one cause on	eautsed the deat each line.	h. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory a	arrest,		t	Approximate nterval Between Onset and Death
4			disease or condition	-				nyopat	hy							
	Examiner							Disea	se							
	p ii	iner	The area from Since to ammers that	Į	Due to	or as a conse	uence of):	22200								
	ecute and I-trans	xam	Cause (Disease or injury that initiated events resulting in death) Last	1	c. Due to	(or as a conseq	uence of):								-	
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9	tificate ig phy as the	ledic														
Вох	death certific e attending pl d for use as t	an/N	IF FEMALE: 23b. Was decedent pregna in the past 12 months'			tcome of pregna		Ectopic pre	gnancy					23d. Date of Month	,	ay Year
		Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□ Pregi 9□ Unkn	nant at time of o own	leath 5	Other (spe	cify)					MONTH	D	ay rear
P.0	law requires that the as been signed by th 2 should be detache		Part II. Other significant co	nditions	contributing to d	eath but not res	ulting in the u	nderlying car	use give	en in Part I.		23e. Did	tobacco	use contribut	e to the	cause of death?
rds	w requires been sigr should be	ed by	Congestive	Heart	: failur	e						1 🗆	Yes 2	<b>X</b> No 3□	Probab	bly 4 □Unknown
Vital Records,	e law re has bee	Completed	Sick Sinus	Syndr	ome							24a. Was		24b. Were	autops	y findings available
<u>~</u>	Th ate pag	Соп	Pulmonary H	vpert	ension								ormed?	deat	h?	□ No
Vits	Physician: The this certificate ral director, pag	Be	25. Was case referred to m examiner?	edical	Hospital:		LEDIO		Othe			(Check only				
of	iding Phys th. After this funeral di	n; To	1 ☐ Yes 2 ☑ No 27. Manner of Death		1	Inpatient 2  of Injury th, Day Year)	ER/Outpatier 28b. Time o	7.141	c. Injury Work	4 🗀 1901		ne 5X Res 28d. Describe			Specify)	
ion	Attanding r death. sctor: After by the fune	atio	2 Accident in	ending nvestigatio	n	tn, Day Year)	Injury	М		r ∕es 2 🗆 1	No					
Division		Certification;		Could not b letermined	28e. Place	of Injury - At hing, etc. (Special	ome, farm, sti fy)	reet, factory,	office		2	28f. Location ( City or To			r Rural F	Route Number,
	To the Hospital or within 24 hours after To the Funaral Discompletely filled in		29a, Certifier 1X Ce	rtifying Pi	nysician: To the	best of my kno	wledge, deat	h occurred a	t the tim	e. date and	d place, a	and due to the	cause(s)	and manne	r as stat	ed
	ne Hos 24 h ne Fur detely	edical	(Check only 2 Me one)	dical Exa	minar: On the b	asis of examina ner stated.	ition and/or in	vestigation, i	in my op	oinion, deat	th occurre	ed at the time,	date and	d place, and	due to th	ne cause(s)
	To the I within 2: To the I	×	29b. Signature and title of c	ertifier	1	11/		29c.	License	number			29d. Da	te signed (M	onth, Da	ay, Year)
•	70+1			4	Hole	14			D213	334			Apri	11,	2004	
	(20)		30. Name and address of p			1			414	. D		#10E 0	\1		200	2.2
	Sta	ite	Daniel J. G 31. Date filed (Month, Day,	Year)	32. F	Redistrar's Signa	ature 4	ice Ph	ack.	Driv	ve, 7	125, 0	ıney	, MID	208	32
	Regist	ar	APR	052	2004	Charles	~	Lake								

			1 - For State Registrar	State of Ma	rylan				ealth a Death	nd M	-	giene Reg. No	21	104	12	71.
	Physici	ian	1. Decedent's Name (First, Middle, La	•							2. Date of De Month	ath Da	ay	Year	3. Time of [	Death
	/Medi Examir	cal	4a. Facility Name (If not institution, giv			rvin	-		Location of		April	40	004 County		2159	М
	Funeral Director			Sex 7. Age		PICAI ast birthday) Yrs.			Ville If Under 2 Hours		8. Date of Bir (Month, Da 6/13/	th y, Year,	onto	9. Birthpl Coun	ry  ace (State or try)  yland	Foreign
	Maryland -f show	tor	Usual Residence of Decedent	mery		ckvil								10	0d. Inside City	
	th with the 23a or 28	al Direc	10e. Street and Number 905 Brice Road				10f. Zip	Code 085	2			10g. Ci	itizen of W	hat Coun	try?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show apportant: If item 27 is marked other than "natural", or items 23a or 28a-f show apportant in items 25a or 28a-f show apportant in items and apportant in a Medical Examinar must be notified at anotae.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Vas Deced f Yes, spec		spanic Origin, Mexican,  Specify:	n? (Spe Puerto I	city Yes or No Rican, etc.)	-	Black	- America k, White, a Whi	etc.	· · · · · · · · · · · · · · · · · · ·
215-0	ithin 72 ho ie. ian "natui Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+	-)		kind of wo OO NOT u	rk done d se retired)	tion furing most o	of working	ng	16b. K	(ind of Bus	siness/Ind	ustry	
Maryland 21215-0036	ild be filed wi lentat Hygien ked other th ic event, the	To Be Con	8 17. Father's Name (First, Middle, Last, Frank Gillioti			Hom	emak	er			(First, Middle, Hawk	Maider	WN H			
	and 2 shou ealth and M n 27 is mar er traumat		19a. Informant's Name/Relationship ( Frank L.Garvin			90	5 Br	ice			Route Numbe					
Baltimore,	t. Pages 1 rtment of H rtant: If iter		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif	h)	CE	ace of Dispo- emetery, crem hesap	eake	cre Cre	em 4/	08/	The second secon	Be	ocation - 0	ille	∍,MD	
Bal	Dermi Depar Impor		21. Signature Winneral Servicy Lior	5		) P 9	HTLT 241	d Address P D Coli	RINA umbia	LDI Bl	FUNE	RAL lve:	SER r Sp	VICE	E,P.A. J,Md20	910
8760,	Physician / Medical physician and physician and physician and physician sill phys	al Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequ consequ consequ	ence of):  opath ence of):	Thy	رعر	, such as ca	Truide of	respiratory ar	rest,		5	Approximate Interval Between Onset and De	een eath
.O. Box 6	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal	death 3 🗌	Ectopic pro Other (sp						23d. Date Mont		y Day Ye	ar
S, P	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but	not resul	lting in the un	derlying ca	ause giver	n in Part I.						cause of dea	
Vital Record		e Completed	25. Was case referred todical						00.00		24a. Was a autop: perfor	med? 2 1 No	pri de	or to com ath?	sy findings av pletion of cau	allable se of
	S S	To B	examiner?	Hospital:	2 🗆 E	P/Outpatient	31260	Othor			Check only or	-	6 ∏Other	(Specify)		
ion of	fter		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Year)	28b. Time of Injury	M 21	3c. Injury : Work? 1 🗆 Yo		28	3d. Describe h					
Division	i Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injung building, etc.	y - At hon (Specify)	ne, farm, stre	et, factory	office		28	3f. Location (S City or Tow	treet and n. State,	d Number )	or Rural	Route Numbe	r,
	To the Hospital within 24 hours a To the Funeral C completely filled it	edical	one)	ysician: To the best of niner: On the basis of e and manner state	xamination	riedge, death on and/or invi	occurred a estigation,	t the time in my opi	nion, death	olace, ar occurred	nd due to the c d at the time, d	ause(s) ate and	and manr place, an	ner as stat d due to t	ed. he cause(s)	
)	2 1 2 2 2	Σ	29b. Signature and title of certifier					License )		?	2		e signed (		2004	
_			30. Name and address of person who of DR DAVID KLE		ith (Item : 90)	23a) (Type, F MEDI		CEN	TER C	DRIV	E ROC	KUI	LLE	GM	2085	6
S.	Sta Registr	_	31. Date filed (Month, Day, Year) APR 0 8 20	32. Registrar	s Signatu	ire &	Los	a Man	,							

**Examiner** physician and s the burial-transit The law requires that the death certificate be executed use as t page or Attending Physician: After death. Hospital

**Funeral** 

Director

•how

r than "naturel", or items 23a or 28a-f ehov the Mudical Examinar must be notified at

filed within 72 hours after

Il Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 ie marked other any injury or other traumatic event, I

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

within 24 hours after death To the Funeral Director: completely filled in by the To the ! 10

Medical

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 4-2-04 29b. Signature and title of certifier 29c. License number D46834 Copiesmo drass of person who address of person 301-22-1701 30. Name and address Ruth Lopez. 7525 Greenway Center Dr. #113 Greenbelt, MD 20770 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2004

Registrar

			1 - For State Registrar	State of Marylan			of Health a of Death	nd Me		iene eg. No. 2 ()	04	12745
ı	Physici	an	Decedent's Name (First, Middle, Last     Irene North Glaz					1	2. Date of Deat Month <b>March</b>	_	004	3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, give Salisbury Nursing	street and number)	ter	4b. City, Tov	vn, or Location of Salis			4c. County	of Death	
	Funeral Director		5. Social Security Number  212–18–6369  Usuel Residence of Decedent	x	last birthday) Yrs.	If Under 1 Y Months D	ear If Under 2 ays Hours	Min	B. Date of Birth (Month, Day, 9–11–19	Vear	9. Birthp Cour	place (State or Foreign ntry) Md.
	within 72 hours efter deeth with the Maryland ane. then "natural", or items 23a or 28a-1 show the Marical Ever it at most burneling at	i Director	10a. State 10b. County  Md. Wicomic  10e. Street and Number  30411 Zion Road		y, Town or Lo alisbu				10	0g. Citizen of \		10d. Inside City Limits 1 □ Yes 2 X No ntry?
-0036	is 1 and 2 should be filed within 72 hours efter deeth with the Marylen of Health and Mental Hyglene. Item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Mexical Exert it are trinsal by inclining an	Completed by Funeral	11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced  15. Decedent's Edu	12. Was Decedent Ever in U. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	16a. Deced	Vas Decedent f Yes, specify I ☐ Yes ②【☐	of Hispanic Origi Cuban, Mexican, No Specify:			14. Rac	ok, White,	te
Maryland 21215-0036	ed within 72 ygiene. ner then "na it, i're Medis	Complet	(Specify only highest grad	College (1-4or 5+)	(Give life. L	kind of work d DO NOT use re ng Assi	one during most of etired)			Nursin	ng Ho	
ryland	hould be fil d Mental H marked ott matic even	To Be	17. Father's Name (First, Middle, Last)  Josephus North  19a. Informant's Name/Relationship (T)	una Print)	19h Mailin	a Address /St		Mae I	Ounn No	rth		Codel
Baltimore, Ma	permit. Pages 1 and 2 s Department of Health an Importent: if item 27 is i any injury or other treui gates.		Charlotte Melvin,  20a. Method of Disposition  1 (Zhuriaf 2   Cremation 3   F  4   Donation 5   Other (Specify)	Daughter 20b. P	30411 lace of Dispo	Zion I sition (Name of natory or other	Rd. Sali	sbury	y, Md.		City or To	
Balti	permit. F Departm Importer any injui		21. Signature of Funeral Service Licens	. 1994(	)							
	Physician /Medical Examiner		23a. Part1. Exter the disease, or compl shock, or heardfailure. List only of Immediate Cause (Final disease or condition resulting in death)	re cause on each line.							-	Approximate Interval Between Onset and Death
8760,	rate be executed hysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)		100					/	
O. Box 6	The law requires that the death certific ate has been signed by the ettending page 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregni Other (specif				23d. Dat Moi	e of delive	ery Day Year
S, D	w requires that been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the ur	derlying cause	e given in Part I.					ne cause of death?
al Reco	: The taw recate has bee	Completed						_	24a. Was ar autopsy perform 1 Yes 2	red?	Vere auto prior to con leath?	psy findings available mpletion of cause of
Division of Vital Record	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	tion; To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c.	Other 4	ing Home	Check only one  5 Resider  d. Describe hor	nce 6 Othe	. , ,	<i>(</i> )
Divisi	To the Hospitei or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, off	lice	28	f. Location (Str City or Town,	eet and Numbe , State)	er or Rura	l Route Number,
	the Hospitel	Medical (	(Check only 2 Medical Exami	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	estigation, in r	my opinion, death	place, and occurred	at the time, da	te and place, a	and due to	the cause(s)
)	To the within 2 To the complete	M	29b. Signature and title of certifier			0	cense number	1	29	d. Date signed	Month,	Day, Year)
D	Sta	ite_	30. Name and address of person who con Dr. William 31. Date filed (Month, Day, Year)	Robins 32. Registrar's Signal				on St	.Suite	,Salisb	ury,	Md.21804
	Registr		APR 0 1 200	14 Dener	10	ppou						

DHMH 17 Rev 1/2001

IRENE DORTHEA GLAZIK

State of Maryland / Department of Health and Mental Hygiene 00 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 2004 **Physician** 10:45 P M 24 WALTER ERIC GIEBELHAUS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York 5. Social Security Number **Funeral** Year) 12 M 2 □ F 1913 Director 086-16-4918 91 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11840 Weller Hill Drive 21770 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Special Events Director Worlds Fair 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othen any injury or other treumatic event Be Florence Marjenhof John Henry Giebelhaus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth B. Brown / Niece 12640 Milesworth Drive Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State March 26, 2004 \* 4 □ Donation 5 □ Other (Specify) Frederick Crematory Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Duena /Medical Due to (or as a co equence of) Ensive Heart Disunse **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examiner burial-transit Due to (or as a consequence of) the attending physician Box 68760 Physician/Medical the ! IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? 2 A No 0 a 1 Yes 110 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No P 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. injury at Work? 28a. Date of Injury (Month, Day Year) 9 Hospitel or Attending Pl 24 hours after death. 9 Funeral Director: After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year, D16428 30. Name and address of pers who completed cause of death (Item 23a (Type Erict) Cline, M.D. 300 W. Ninth Street Frederick, Maryland 21701 Casper E. strar's Signature 32. Rg Registrar

			1 - For State Registrar	State of Man	,	artmen	t of H	ealth ar		ental Hyg	2.0	04	1274	+7
	Physici /Medic		1. Decedent's Name (First, Middle, Las Robert Lee Hars	-					Y	2. Date of Deat Month NARCH	ale 2	OO4	3. Time of Dear	th OM
}	Examin			Late of Death Death County County Humber of Secretary Process and Authors of Process and Au										
	Funeral		5. Social Security Number 6. S	ex 7. Age (i		If Under	1 Year	If Under 24	4 Hrs.	8. Date of Birth	Reg. No. 2001  and Death Day Year 7. 4c. Country of Death Washington  and Birth Day, Year 9. Birthplace (Sta Country)  Accountry Maryland  10d. Inside 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ace (State or For	eign	
	Director		220-20-2001	<b>□Y Y</b> 2 □ F	70 Yrs.	WOITUIS	Days	Tiours		Dec.22,	1933			
	yland now			11	Oc. City, Town or L	ocation						10	d. Inside City Lin	nits
	I within 72 hours after death with the Maryland jene. I than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Director	Md. Washir	ngton	Mauga	ınsvil	le_						1∭(Yes 2□	No
	with th	Dire	17000 Constant Street and Number	٥		10f. Žip		<b>47</b>		1	•		try?	
	leath	Funeral	13922 Greenfield  11. Marital Status		er in U.S. 13.	Was Deced			n? (Spec	ify Yes or No-			an Indian,	
9	after d or Item		1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 💢 Yes 2 🗌 No					Puerto R	ican, etc.)				
Maryland 21215-0036	ural', o	d by	3 Widowed 4 Divorced	Year or Dates:										
15	c * 00	Completed	(Specify only highest gra	de completed)	(Give	e kind of wor	rk done d	furing most o	of working	g	16b. Kind of B	usiness/ind	ustry	
212	illed within I Hygiene. other than "rent, I'm Mer	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Tan	nery				Securi	ty Ga	urd	
П		Bec	17. Father's Name (First, Middle, Last)				100000000000000000000000000000000000000	18. Mother's	s Name	(First, Middle, I	Maiden Suman	ne)		
ryla		ပ္	Roger L. Harshman		10h Mail	ing Address	(Street o		100			State 7in	Codol	
Ma	- E N =				1	-								
ē,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition					۱ ا	Da	ite				
Ē	8 = 5		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify								Hager	stown	,Md.	
Baltimore,	permit. Pag Department Important: I any injury o		2 Signature of Funeral Service Lic-	see .					]	2525 B:	radbury	Ave.		
	20 E # 0			plications that caused th	o D	avis	Fune	ral Ho	ome c	Smithsbu	urg, Md.	2178		
	Pnysician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  Esophageal  Due to (or as a c	adenocarci								Interval Between Onset and Death	
8760,	icate be executed physician and sthe burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a c										
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim	☐Fetal death 3								•	
ds, P.	w requires that been signed b should be deta	þ			_	underlying c	ause give	en in Part I.		V				
of Vital Records,	aw req	Completed	severe protein and ca	lorie malnutri	tion						n 24b.	Were autop	sy findings availa	able
R	The lav	mo								perform	ned?	death?		OI.
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	11a-sizel										
<del>o</del>	hys this al dia	<u>د</u>	1 ☐ Yes 2 📉 No 27. Manner of Death	1 L Inpatient			JA	4M IAMI2	-					
O	ding After fune	tlon	1 Natural 5 ☐ Pending		(ear) Injury					od. Describe no	w injury occur	160		
Division	Il or Attendi after death. Diractor: A d in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be	286. Place of injury	- At home, farm, s Specify)	treet, factory	, office		28	3f. Location (Sti City or Town	reet and Numb , State)	er or Rural	Route Number,	
	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	Medical C	29a. Certifier (Check only one) Certifying Ph	niner: On the basis of ex	ramination and/or i	th occurred nvestigation	at the tim , in my or	e, date and pinion, death	place, an	nd due to the ca	tuse(s) and ma ate and place,	anner as sta and due to	ited. the cause(s)	
		Ň	29b. Signature and title of certifier	-	A .	<u> </u>				29				,
	ax\		1		] '(							4 2	7,2000	+
4	.2 <sup>X1</sup>		TERRY L			_			-		enue			
	Sta Regist		31. Date filed (Month, Day, Year) MAR 29 2	32. Begistrar's	Signature	outs								

			_ State		artment of Health and I		2001
			Registrar  1. Decedent's Name (First, Middle, Last)		uncate of Death	Reg. I	3. Time of Death
	Physici /Medic	al	Jess M. Hopkins, J	Ir		March 29	Day Year 2004 1:45 PM
1	Examin		4a. Facility Name (If not institution, give street and i	number)	4b. City, Town, or Location of Death		4c. County of Death
	Francis		1341 Cedarwood Driv	7. Age (In yrs. last birthday)	Hagerstown  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	Washington County  9. Birthplace (State or Foreign
П	Funeral Director		578-38-4593 15x M 2□F		Months Days Hours Min.	April 14,	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	Maryl -f sho	tor	Maryland Washington	Hagersto	own		1 XYes 2 □ No
	or 28a	)lrec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	s 23a	rai	1341 Cedarwood Drive	ecedent Ever in U.S. 13. \	21742	positu Vos er Ne	U.S.A.  14. Race - American Indian,
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 Is marked other than "netural", or Items 23a or 28a-f show other traumatic event, the Medical Examirar must be incliffed at	by Funeral Director	Armed	s 2 □ No	Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.  Specify: White
21215-0036	72 ho 'netur	Completed	15. Decedent's Education (Specify only highest grade complete	d) 16a. Deced	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b	. Kind of Business/Industry
121	within lene. than	dmo		(1-4or 5+)	countant	1	'ederal Government
	filed withi Hygiene. other than rent, the M	Be Co	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	den Sumame)
/lar	should be ind Mental is marked o	To B	Jess M. Hopkins, Sr.			Hodges	
Maryland	12 sho h and 7 le mu traum		19a. Informant's Name/Relationship (Type, Print) Ann Marie Hopkins/Daug		ng Address (Street and Number or Ru 1 Cedarwood Drive		y or Town, State, Zip Code) wn, Maryland 21742
ຜົ	ges 1 and 1 of Health If item 27 or other tr		20a. Method of Disposition	20b. Place of Dispo		-	Location - City or Town, State
Ē	Pages sent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro	Smithsb	urg Crematory Mar	.30, 04 Sm	ithsburg, Maryland
Baltimore,	permit. Pages 1 Department of H Importent: If ite any Injury or of once.		21. Signature of Funeral Service Licensee	when K 1		_	'iery Funeral Home stown, Maryland 21742
I			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause o	at caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
,	Pnysician /Medical	e i	Immediate Cause (Final disease or condition resulting in death)	Prec	sinon		4 days
	Examiner		Due	to (or as a consequence of):	ic Obstrutive	Culman	Disease 15 Va
	P #	ner	Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury	to (or as a nonsequence of):	12 0 100 1000000	10:10	
	ecuter and -trans	Examiner	triat initiated events	to (or as a consequence of):			
8760,	sate be executed oblysician and the burial-transit	ia E	333	(o) (o) (a) (a osinosquonos oi/).			
9	ifficate g physas the	edic					
O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medicai	23b. was decedent pregnant 1 Liv	egnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
, P.O	s that the de ned by the a e detached f	by Ph	Part II. Other significant conditions contributing to	o death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?
ğ	iw requires that s been signed b should be deta	ted t				1 🛮 Yes	2 No 3 Probably 4 Unknown
of Vital Records,	The law rate has be page 2 sh	Completed				24a. Was an autopsy performed 1 Yes 2	
Vita	certific	o Be	25. Was case referred to medical examiner?  Hospital:			th (Check only one)	6  ☐Other (Specify)
ō	p Phy er this eral di	$\vdash$	27. Manner of Death 28a. Da	☐ Inpatient 2 ☐ ER/Outpatien  te of Injury 28b. Time of  Injury Injury		28d. Describe how in	
ion	ath. or: Afte	atio	2 Accident investigation	fonth, Day Year) Injury	M 1 Yes 2 No		
Division	tal or Atto	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Pla	ace of Injury - At home, farm, str ilding, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medical Examiner: On the one)		n occurred at the time, date and place vestigation, in my opinion, death occu	rred at the time, date a	and place, and due to the cause(s)
	with To T	Σ	29b. Signature and title of certifier	/ 4 2	29c. License number		Date signed (Month, Day, Year)
	Triox,		30. Name and address of person who completed co	ause of death (Item 23a) (Type,	Print)	1 1	3-30.04
	),		31. Date filed (Month, Day, Year). 32	Registrar's Signature	Medical Comp	us Desc	erstun MP
χ. γ.	St. Regist	ate rar	MAR 31 2004	Design 13 Signature	A. A. Shirt		

			1 - For State Registrar	State of	Marylan	-	artment rtificate			and M	lental Hy	giene Reg. No. 🤈 (	) N.L.	1271.0
	Physici		1. Decedent's Name (First, Middle, Last) Allen Harold HADD(	OCK							2. Date of De	ath Day	Y99'3/	3. Time of Death
	/Medie Examir		4a. Facility Name (If not institution, give s 1418 Salem Avenue	treet and num	·				Location o	of Death		Wa	ty of Death	ton
	Funeral Director		217-20-1203	M 2□F	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Jan • 2	th y, Year) 2,1930	9. Birthpl Coun Penn	ace (State or Foreign try) Sylvania
	Maryland s-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Washing	gton	10c. City	/, Town or Lo	cation Hage:	rsto	wn				10	0d. Inside City Limits 1 ⊠Yes 2 □ No
	with the	I Director	10e. Street and Number 1418 Salem Avenue	Exten	ded		10f. Zip	Code 217	40			10g. Citizen o	What Coun	try?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28s-f ehow other traumatic event, the Medical Examinar must be notified at	by Funeral			dent Ever in U. ces? 2   No		Was Deced f Yes, spec			gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bl	ace - America ack, White, 6	etc.
Maryland 21215-0036	d within 72 ho giene. or then "netur the Medical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		4or 5+)	16a. Deced (Give life. L	kind of won DO NOT us	l Occupa k done d e retired)	tion u <i>ring m</i> osi	t of worki	ing	16b. Kind of		company
land	12 should be filed within n and Mental Hygiene. Is marked other than "raumatic event, the Max	To Be C	17. Father's Name (First, Middle, Last) Harold C. Haddock								(First, Middle, Frances			
Mary	and 2 shou eelth and M n 27 Is mar er traumat	-	19a. Informant's Name/Relationship (Type Mark Haddock - nep								Hagerst			,
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ri '4 ☐ Donation 5 ☐ Other (Specify)	emoval from Si	lale	lace of Dispo emetery, cren lar Lav			. 1	3/27	7/04	20c. Location	-	wn, State Maryland
Balti	permit. Pege Department of Importent: If any injury or		21. Signature of Funeral Service License	m	Vin		/			MIN	NICH FU	JNERAL	HOME	<del>-</del>
68760,	The law requires thet the death certificate be executed by EX Mark the Steen signed by the attending physicien and minimized property or as the burial-transit or or or or or or or or or or or or or	dical Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	r as a consequence of the conseq	rence of):	ish	In Ale	7	Fell .	) · · · ·	-2V2		Approximate Interval Between Onset and Death
P.O. Box 6	thet the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live bir	ome of pregnar th 2 ☐ Fetal nt at time of de vn	death 3	Ectopic pre Other (spe						ate of deliver onth	y Day Year
	quires thet the sound by the column and perfect the column and the	þ	Part II. Other significant conditions con	tributing to dea	ith but not resu	Iting in the un	nderlying ca	use give	n in Part I.			es 2 No	3 Proba	cause of death?
of Vital Records,		Completed	,								24a. Was a autop perfor	sy	prior to com death?	sy findings available pletion of cause of
f Vita	yeician iis certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 🗆 inp	patient 2 🗆 E	ER/Outpatient	3 DO	Other	_		(Check only on		her (Specify)	
Division o	ath. or: After	Certification;	27. Manner of Death 1 Chatural 2 Accident 3 Suicide 4 Homicide	28e. Place o	Injury Day Year) Injury - At horal to the second of the se	28b. Time of Injury me, farm, stre	м		at ? es 2 □ N	10	28d. Describe h	treet and Num		Route Number,
	nour life	Medical Ce	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the ber: On the bas	is of examinati	vledge, death ion and/or inv	occurred a estigation,	t the time	e, date and	d place, a	and due to the c	ause(s) and m late and place,	anner as sta and due to t	ted. he cause(s)
	To the within To the comple	Me	29b. Signature and title of certified	MI	/		29c.	License	number	_	2	3-26	ed (Month, D	ay, Year)
54	121		30 Hame and address of person who con	nybleted seuse	of death (Item	2367 (Type. [	rid g û g	to4	202	As	egriston.	0: No	1/217	
Şu	Sta Registr		31. Date filed (Month Day Year) 9 20	32. Res	gistrar's Signat	ure A. A.	rese			,		,		

		1	State of Maryland / Department of Health and N  1- State Registrar Certificate of Death	Mental Hygie	20114	12750
			Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Carlton H. Hancock		2 04	18:45 M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	
			Snow Hill Nursing Home Snow Hill  5 Serial Security Number 16 Sery 7 Age (In vrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Worcest	
	Funeral Director		225-18-3329 1MM 2 F 82 Yrs. Months Days Hours Min.	8   1   2 1	par) Silu	place (State or Foreign intry)
	and w	}	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		-	10d. Inside City Limits
	Maryl f sho	ğ	VA Accomack Wattouille			1 ☐ Yes 2 No
	the redi	rec	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	intry?
	h with	Funeral Director	7511 Wallops Mill Pond Road 23483		U.S.A.	
	ema	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 1f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
ဓ္က	or it	by F.	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify:		Specify:	nite
ë	hours tural'	d be	3 Widowed 4 Divorced Year or Dates: WW II   15. Decedent's Education   16a. Decedent's Usual Occupation	166	b. Kind of Business/I	
5	within 72 hours after death with the Maryland ene. Than "natural", or itema 23a or 28a-f show the Medical Everities in ast be rediffed at	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	ing		·
21215-0036	d with giene.	mo:	12 Radar Operator		N. A.S. H	1.
힏	be filed Ital Hygi Id other evant, I	Be C		e (First, Middle, Mai	1.0	
Maryland	should b and Ment marked	2	Miles Hancock Berth			
Jar	2 shot and and less many l	7	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run	0 10	1 1 1 1 1	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show amy injury or other traumatic event, the Medical Exercitival resist be redified at once.	1		Date 200	Location - City or 1	Town, State
Baltimore,	Pages nent of I ant: If its ury or o		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State	T		
럂	permit. Pa Departmen Important any injury		'4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Picility	5104 T	Church :	Street
Ba	Depa Impo any i		I amanda C. Betts Solver Funeral Hor		coteaque	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	Deme	entra	Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):			
	Examiner		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	ed sit	iner	di ary, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	and and al-tran	Examin	that initiated events c			
68760	death certificate be executed e attending physician and of for use as the burial-transit	calE	d			
687	ificate g phy as the	P				
Вох	leath certificat attending phy I for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	very Day Year
	e deat he att		in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown		Month	Day real
P.0	that the de ed by the a detached t	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	sign d be	d by	F	1 ☐ Yes	2, No 3 □ Pro	obably 4 Unknown
Sor	w requ been shouk	e Completed		24a. Was an	24b. Were au	topsy findings available ompletion of cause of
Re	he lav e has age 2			autopsy performed 1 ☐ Yes 2	d? death? INo 1 ☐ Yes	ompletion of cause of 2'x2"No
Vital	sician: The certificate hi rector, page		25. Was case referred to medical 26. Place of Deal	th (Check only one)	110	
<u>&gt;</u>	\$ 0 D	To B	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Ho	ome 5 🗆 Residenc	e 6 Other (Spec	ufy)
n of	Jing Ph h. After th funeral			28d. Describe how	injury occurred	
Sio	Attending it death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	29f Location (Street	et and Number or Ru	ral Route Number
Division	or Attencater death Director: in by the	Certification;	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide	City or Town, S		ar riosto remoon
ليبا	Hospital 24 hours a Funeral I tely filled					
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur one)			
	To the within 2 To the complet	Ř	. (////////////////////////////////////		Date signed (Month	
		1	Gregoris M. Tellow Ma. D 29505	0.	4-03-	2004
, L	271	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	or entre	セックシ い	D 71041
	1.341		GREGORIO M. BELLOSO, M.D., 5302CHINABERRY D  31. Date filed (Month, Par, Year) 6 2004  32. Segistrar's Signature  APR 0 6 2004	K., 34 -15	suicy, M	V 21801
	St Regist	ate rar	31. Date filed (Month, Par, Year) 6 2004 32. Signature			

Physician   Medical Examiner   M	Isual Residence of Decedent  Oa. State  Oa. State  I Ob. County  Prince G  Oe. Street and Number  O4 Hill Rd. # 2  1. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced  Is. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0·12)  1 2 th  7. Father's Name (First, Middle, Last)  John Wesle  19a. Informant's Name/Relationship (Tyk Bobby Harris, Brote)  Oa. Method of Disposition	Hospital  M 2NF 7. Age (In yrs. Ias 63  Leorge's 10c. City, Hyd  2. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 1 No If Yes, Give Year or Dates:  Cation o completed)  College (1-4or 5+)	Town or Location attsvil:  13. Was De If Yes, s 1 Yes, s	Le Zip Code 20785 cedent of Hispapecify Cuban, k	Y Under 24 Hrs. Hours Min.  Min.  Anic Origin? (Spudexican, Puerto		Dey 31 2 4c. County Prince 1940 10g. Citizen of WUSA	9. Birthplace (State of Country)  10d. Inside C 1 X Yes  What Country?  e - American Indian, etk, White, etc.	or Fore	
Parmir S should be like the standard by the st	Social Security Number 241-62-8552 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. las 63  Feorge's 10c. City, Hyd  10. Age (In yrs. las 63  10c. City, Hyd  10. Age (In yrs. las 63  10c. City, Hyd  10c. City,	Town or Location attsvil  10f.  13. Was De if Yes, s  1  Yes  16a. Decedent's U (Give kind of ifte. DO NO  Clerk	Le  Zip Code  20785  cedent of Hispa cedent of Hispa cedent of Wispa cedent of Size No. S	anic Origin? (Sp. Mexican, Puerto	Dec 27,	1940 10g. Citizen of V USA	N 10d. Inside C 1 X Yes What Country?  e - American Indian, ck, White, etc.	IC.	
Department of the Bath and Mental Myslene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other treatments event, the Medical Examiner must be notified at one of the standard of the modern or Items 23s or 28s-f show any injury or other treatments event, the Medical Examiner must be notified at one of the modern or Items 23s or 28s-f show any injury or other treatments event, the Medical Examiner must be notified at one of the modern or Items 23s or 28s-f show any injury or other treatments of the modern or Items 23s or 28s-f show any injury or other treatments of the modern or Items 23s or 28s-f show any injury or other treatments of the modern or Items 23s or 28s-f show any injury or other treatments of the modern or Items 23s or 28s-f show any injury or other treatments of the modern or Items 23s or 28s-f show any injury or other treatments of the modern or Items 23s or 28s-f show any injury or other treatments or Items 23s or 28s-f show any injury or other treatments or Items 23s or 28s-f show any injury or other treatments or Items 23s or 28s-f show any injury or other treatments or Items 23s or 28s-f show any injury or other treatments or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injury or Items 23s or 28s-f show any injur	Oa. State MD.  10b. County Prince G  Oe. Street and Number  04 Hill Rd. # 2  1. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade)  Elementary/Secondary (0-12) 1 2 th  7. Father's Name (First, Middle, Last) John Wesle  19a. Informant's Name/Relationship (Tyx Bobby Harris, Brot)  Oa. Method of Disposition	eorge's Hya  12. Was Decedent Ever in U.S. Armed Forces? 1   Yes 2   No	13. Was De If Yes. S 1 Yes. S (Give kind of life. DO NO Clerk	Zip Code  20785  cedent of Hispa specify Cuban, N	Specify:		USA 14. Race Blace	1 💆 Yes What Country?  e - American Indian, k, White, etc.	-	
Department of Health and Annual De linds within the performance of Health and Mental Hygiene importent: if item 27 is marked other than enythiury or other freumatic event, the Medical Comparison of the performance of the p	1. Marital Status 1 Never Married 2 Marned 3 Nover Married 2 Marned 3 Nover Married 2 Marned 3 Nover Married 2 Marned 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 12th 7. Father's Name (First, Middle, Last) John Wesle 19a. Informant's Name/Relationship (Tyr. Bobby Harris, Brot	12. Was Decedent Ever in U.S. Armed Forces? 1   Yes   No If Yes, Give Year or Dates: cation completed) College (1-4or 5+)  Py Harri	13. Was De If Yes, s  1 □ Yes  16a. Decedent's U (Give kind of ifte. DO NO  Clerk	20785 cedent of Hispa specify Cuban, N	Specify:		USA 14. Race Blace	e - American Indian, k, White, etc.		
Department of Health and Annual De linds within the performance of Health and Mental Hygiene importent: if item 27 is marked other than enythiury or other freumatic event, the Medical Comparison of the performance of the p	1 Never Married 2 Marned 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12) 12th  7. Father's Name (First, Middle, Last) John Wesle  19a. Informant's Name/Relationship (Tyx) Bobby Harris, Brot	Amed Forces?  1  Yes 2 No If Yes, Give Year or Dates:  cation College (1-4or 5+)  Py Harri	1 □ Yes 16a. Decedent's U (Give kind of life. DO NO Clerk	2 No S	Specify:	ecify Yes or No- Rican, etc.)		ck, White, etc.		
Department of Health and Annual De linds within the performance of Health and Mental Hygiene importent: if item 27 is marked other than enythiury or other freumatic event, the Medical Comparison of the performance of the p	(Specify only highest grade Elementary/Secondary (0·12) 12th 7. Father's Name (First, Middle, Last) John Wesle 19a. Informant's Name/Relationship (Tyr. Bobby Harris, Brot	College (1-4or5+)  Ey Harri	(Give kind of life. DO NO Clerk	sual Occupation work done durin Tuse retired)	n na most of work		y Yes or No- an, etc.)  14. Race - American Indian Black, White, etc.  Special Lack			
Physician di /Medical re Examiner	John Wesle  19a. Informant's Name/Relationship (Tyx) Bobby Harris, Brot	-			g og Gr HOIK	ing	16b. Kind of Bu	ate		
Physician di /Medical re Examiner	Bobby Harris, Brot		arris 18. Mother's Name			e (First, Middle, Maiden Sumame) Haddock				
Physician di /Medical re Examiner		19a. Informant's Name/Relationship (Type, Print)  Bobby Harris, Brother  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 726 Circle Dr. Greenville, NC. 27858						State, Zip Code)		
Physician di /Medical re Examiner	1 🔀 Burial 2 ☐ Cremation 3 ☐ Ro 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State  20b. Platicent Cent Home	ce of Disposition (inetery, crematory (esteas Ce	Name of or other place) metery	4/6/0	Date 4	20c. Location - Greenvi	City or Town, State		
Physician India /Medical Examiner	21. Signature of Funeral Service Licensee  ### MOI 251  22. Name and Address of Facility  Bianchi F.S. 814 Upshur St. NW, Wash. DC 20						20011			
e be executed //sician and e burial-transit cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque  SEPS IS  Due to (or as a conseque  KESPIRATOR  Due to (or as a conseque	nce of):	ESOPI ILURE	1 KGU S					
death certifical e attending phy difor use as the disciplination of the disciplination o	IC CCNAN C.	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	leath 3 Ectopi	c pregnancy (specify)	=15-2			te of delivery onth Day	Year	
een signed by the nould be detached by Physical By Phy	Part II. Other significant conditions cor	ntributing to death but not result	ing in the underlying	ng cause given i	in Part I.		obacco use cont (es 2 □ No	ribute to the cause of	,	
the taw the taw the taw the taw the taw the taken the taw the						24a. Was autop perfor	sy property of	Were autopsy findings prior to completion of death? 1 ☐ Yes 2 ☐ No	ava caus	
	25. Was case referred to medical examiner?  1 X Yes 2 □ No	Hospital: 1 X Inpatient 2 ☐ E	R/Outpatient 3	Other	6. Place <u>of Deat</u> 4 ☐ Nursing Ho		Check only one)  5 ☐ Residence 6 ☐ Other (Specify)			
After fune	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M		s 2 No	28f. Location (Street and Number or Rural Route Number			mber	
	4 Homicide determined  29a. Certifier & Certifying Physics	building, etc. (Specify)	City or Town, State)  occurred at the time, date and place, and due to the cause(s) and manner as stated.							
the Hosp thin 24 hou the Fune mpletely fil Medical	(Check only 2 Medical Examinate)  29b. Signature and title of certifier	ner: On the basis of examination and manner stated.	on and/or investiga	tion, in my opini				and due to the cause(		
o Name o S	Deun Jeun						3/3	1/04		
	30. Name and address of person who co		23a) (Type, Print) OSPITAL	DOD5 DRIVE	1 3.5	CHEVER	ery M	7 20785	-	

DHMH 17 Rev 1/2001

ORIGINAL

	_1	For State Registrar		Department of Health and Certificate of Death		iene 19. No2 0 0 13 1	275	
Physician /Medical Examiner	n I	4a. Facility Name (If not institution, give	nry Harris S	t.  4b. City, Town, or Location of De	_	Day Year	Time of Deat	
Funeral Director	Millennium Health of Forestville Forestville P.G.  5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) 15. Months Days Hours Min. Sept. 4, 194 1. Usual Residence of Decedent							
or 28e-f show be notified at		10a. State 10b. County  Md • P • G •	10c. City, Town	estville			nside City Lin ⊠Yes 2□	
23e or 2 ust be n		10e. Street and Number 7420 Marlboro	Pike	10f. Zip Code 20747		og. Citizen of What Country? United Stat	es	
Hygiene the "natural", or items 23e or 28e-f show out, the Medical Examinar must be notified at a Completed by Funeral Director	<u>`</u>	11. Marital Status  1 □ Never Married 2☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1XIYes 2 □ No If Yes, Give Year or Dates: 1955	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 ☐ Yes 2☑ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American In Black, White, etc. Specify: Black	dian,	
iene. rthen "natural", the Medical Exa	10 B	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 1 2	de completed)	Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)  tropolitan Polic	vorking	6b. Kind of Business/Industry		
nd Mental Hyg marked other umatic event,		17. Father's Name (First, Middle, Last) Unknown		18. Mother's N	ame (First, Middle, M ce Harris	laiden Sumame)		
Department of Health and Mental Hygiene. Importent: If item 27 is marked other then many niury or other treumatic event, Item 2008.  To Be Commit		19a. Informant's Name/Relationship (T.  Nancy Harris/V  20a. Method of Disposition  1	Removal from State 20b. Place of cemeter	Mailing Address (Street and Number or 232 Nova Avenue apitol Heights, Disposition (Name of y, crematory or other place)  1n Mem. Cem. 4/1	Date 26	City or Town, State, Zip Code 13 Oc. Location - City or Town, S Suitland, Me	State	
Departm Importer any injur once.		21. Signature of Funeral Service Licens		22. Name and Address of Facility I	Hodges &	Edwards F.	1.	
hysician and Medical was libraries in the burial-transit must be bur	Z Z	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last		6	et and Dea			
by the attending place tached for use as the action of the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day	Yea	
be of	Š	Part II. Other significant conditions co	ontributing to death but not resulting in	n the underlying cause given in Part I.		acco use contribute to the cau c 2ቜNo 3☐ Probably		
ate has page 2					24a. Was an autopsy performe 1 ☐ Yes 25	prior to completi death?	on of cause	
r death. ector: After this certificate h by the funeral director, page iffication: To Be Com	2	examiner?				ath (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred		
ath. r: After e funer		Z Accident	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
urs after death. rel Director: After t lled in by the funera Certification:	T T T T T T T T T T T T T T T T T T T	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)		4			
in 24 hours after death.  he Funerel Director: At pletely filled in by the fun edical Certification	COLCA	3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Specify)  /sician: To the best of my knowledge	, death occurred at the time, date and plat d/or investigation, in my opinion, death occ	ce, and due to the cau curred at the time, date	use(s) and manner as stated. e and place, and due to the c	ause(s)	
within 24 hours after death. To the Funerel Director: All completely filled in by the fur	enica	3 Suicide 4 Homicide  6 Could not be determined  29a. Certifier (Check only) 2 Medicel Exemi	building, etc. (Specify)  /sician: To the best of my knowledge iner: On the basis of examination and	death occurred at the time, date and plated or investigation, in my opinion, death occurred 29c. License number	curred at the time, date	use(s) and manner as stated. e and place, and due to the c d. Date signed (Month, Day, 1) erch 30, 200	(ear)	

State of Maryland / Department of Health and Mental Hygiene

**ORIGINAL** 

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

7 2004

		·	1 - State Registrar AMEND#17per II	State of Ma		0-			lealth a Death			Reg. No.	7007	12754
ı	Physici /Medic		1. Decedent's Name (First, Middle, La: Margaret M. H:	st) i11							2. Date of De Month	Day	200	
	Examin		4a. Fecility Name (If not institution, giv Shady Grove Adver		ital		4b. City		ckvil		V		County of De	
	Funeral Director		5. Social Security Number 6. S 193-03-2726	Sex 7. Agu	e (In yrs. 95	last birthday) Yrs.	If Und Months	er 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, Da Oct.	rth ay, Year)	9. B	irthplace (State or Foreign Country)
	and and		Usuet Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	a-f sho	ctor	MD Montgome	ery		I	Rocky	ville						1∭Yes 2 ☐ No
	with the a or 28	Director	10e. Street and Number 298 Lynch Street	-			10f. Z	ip Code	0850				zen of What (	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show mimortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any joury or other traumatic avent, it a Medical Examination and be notified at ADGE.	by Funeral	11. Maritat Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ I If Yes, Give Year or Dates:						gin? (Spec , Puerto F	cify Yes or Ni Rican, etc.)		ted St. 14. Race - An Black, Wh Specify: W	nerican Indian, nite, etc.
21215-0036	"natur	Completed by	15. Decedent's E (Specify only highest gra			16a. Dece	dent's Us	ual Occup	ation during most d)	of workin	g	16b. Ki	nd of Busines	s/Industry
212	d withir giene. or then	omo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	_	_	aker					Own	Home
Maryland	uld be file Mental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last, John Yatzeck -	Ganzer <del>Dryal</del>							(First, Middle ine D		Sumame)	
	and 2 should balth and Men n 27 is marke	•	19a. Informant's Name/Relationship ( Lillian M. Soya/	* '				·			Route Numb		r Town, State 20850	
nore,	Pages 1 and Hear of Hear Int. If item Inty or othe		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □  1 □ Donation 5 □ Other (Specific			Place of Disponentery, createry, createry				Apri	1 04 <sup>5</sup>			a, Virginia
Baltimore,	permit. P Departme Importan any Injury		21. Signature of Euneral Service Lice		)	22	2. Name	and Addre	ss of Facility	De	Vol Fu	nera		. 10 East
760,	Physician / Medical Examiner period of period	ical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as  c. Due to (or as  d. Due to (or as	a conseq	puence of): quence of):		-						Approximate Interval Between Onset and Death
.O. Box 68	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	ul déath 3	⊒Ectopic ⊒ Other (	pregnancy specify)	,				23d. Date of d Month	lelivery Day Year
4	uires that signed by d be deta	þ	Part II. Other significant conditions of	contributing to death b	out not res	ulting in the u	inderlying	cause giv	en in Part I.			tobacco u Yes 21		to the cause of death?  Probably 4 Skinknown
al Records,	: The law requires that the cate has been signed by th page 2 should be detache	Completed									24a. Was auto perf 1 \( \text{Yes}	psy ormed?	prior to death?	
Vital	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner?  1 \( \sum \) Yes 2 \( \sum \) No	Hospital:	ent 2 🔀	PER/Outpatier	nt 3 🗆 (	OCA Oth	000		(Check only		5 □Other (Sp	nacify)
on of	ding Phys Ih. After this funeral di	<b>—</b>	27. Manner of Death  1 SNatural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	1LA	28b. Time o		28c. Injur Wor		2	8d. Describe			
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined		jury - At h tc. (Specia	ome, farm, st fy)	reet, facto	ory, office		2	8f. Location City or To			Rural Route Number,
	P Hospital 24 hours a P Fureral C etely filled	edical (		hysician: To the best miner: On the basis o and manner st	of examina									
	To the within 2 To the complet	Me	29b. Signature and title of certifier	507			2	9c. Licens	e number			29d. Dat	e signed (Mo	nth, Day, Year)
	Ų		30, Name and address of person who	X terre	en last	D 23a\ (Tub=	Print	036	979		The state of the s	a	pul	4,2004
			30. Name and address of person who	Annihiered garde of C				CE	ntel	~ O:	c. Ro	CKU.	•	0 311 8/56
Α.	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 6 2	32. Registr				Day V					,	375

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** FRRYH. April 6, 2004 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescence Center Crofton Anne Arunde1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1⊠ M 2□ F Months Hours Vrs 073-05-9144 93 Director March 24, 1911 New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
ther than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Prince George's Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9000 Briarcroft Lane, USA Funeral #348 20708 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 M Yes 2 No If Yes, Give WWII Year or Dates: WWII 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White Completed by 3 ☐ Widowed 4 🗓 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify onfy highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Circulation Manager News Letter permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyoir Important: If Item 27 is mericany injury or other. other traumatic event. 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert C. Hull Eslie M. Hunt 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perry H. Hull/ Son 1138 East Sherman Avenue, Salt Lake City, UT 84105 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 7, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2004 Alexandria, Virginia 21. Signature of Fyneral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Cobe 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the reach. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner burial-transit Attending Physician: The law requiras that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for usa as the buria Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown lernia þ certificate has been signe lirector, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy TITYES 21/No 1 ☐ Yes 2 ☐ No ours after death.

eeral Diractor: After this certifical filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 ☐ Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1-54 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ò To the Hospital of within 24 hours at To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Chec) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ADTICA CUOPRA 04

Registrar

State

Cheverly, MD 20785

rocks

6001 Landover Rd.,

32. Registrar's Signature

80. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Aditya Chopra M.D.

31. Date filed (Month Pay

٠٢.	ILEINDEIK	,	For State Registrar	State of Marylar			of Health a of Death	•	giene Reg. No 20 (	14 12756				
			1. Decedent's Name (First, Middle, Las	t)				2. Date of De	nath Day	3. Time of Death				
	Physicia /Medic		Tre Hendersho	ot				March						
	Examin		4a. Fecility Name (If not institution, give 9000 Louis Avenue				wn, or Location of 7er Spri		4c. County o					
					last histoday)	If Under 1 Y		9		gomery				
	Funeral Director			M 2□F 7. Age (in y/s.	Yrs.		ays Hours		3, 1992	Birthplece (State or Foreign Country)				
			Usuel Residence of Decedent	11	<del></del>			1002) 1	3, 2332	Ohio				
	arylan show	_	10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No				
	the Ma 28a-fa	Director	Maryland Montgor	nery S	Silver	-								
	nith th	Dire	10e. Street and Number			10f. Zip Co			10g. Citizen of WI					
	eeth w	erai	9000 Louis Street	t 12. Was Decedent Ever in U	IS 13	1	0901 t of Hispanic Ori	gin? (Specify Yes or No	US.	A - American Indian,				
"	after deeth with the Maryla or Nems 23e or 28e-f shov ruiner must be notified at	Funerai	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No				gin? (Specify Yes or No n, Puerto Rican, etc.)	Black	, White, etc.				
036	hours after deeth with the Maryland tural, or Items 23a or 28a-f show al Exeminer must be mullied at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2🏡	No Specify:		Specify:	Black				
21215-0036	2 5 5	Completed	15. Decedent's Ed (Specify only highest grad		16a. Dece (Give	dent's Usual O kind of work d	ecupation done during mos etired)	t of working	16b. Kind of Bus	iness/Industry				
121		dw	Elementary/Secondary (0-12)	College (1-4or 5+)		Student			Educat	ion				
d 2	filed Hygid Sther ent,		17. Father's Name (First, Middle, Last)		1	o caacii c		er's Name (First, Middle						
lan	lid be fental rked o	To Be	Unknown				E1y	cia M. Hend	lershot					
Maryland	s 1 and 2 should be filed within ' I Health and Mental Hygiene. Item 27 Is marked other than 'i		19a. Informant's Name/Relationship (7	Гуре, Print)	19b. Mailir	ng Address (Si	treet and Numbe	er or Rural Route Numb	er, City or Town, S	tate, Zip Code)				
≥,	and seatth m 27		Brian D. Hendersho					oad, Columb						
Baltimore,	Fire H of H			Removal from State	cemetery, crei	osition (Name of matory or other	r place)	April 5,		City or Town, State				
Iţir	it. Pa		and the state of t											
Ba	permit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other treugnes.		1 (Inohew )	Cole	50	0 Unive	ersity I	31vd. W., S	ilver Spi	ring. MD 20901				
			23a. Pert1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the dea	th. Do not ent				rrest,	Approximate Interval Between Onset and Death				
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Multiple		and ci	utting	wounds						
	Examiner			Due to (or as a consec	tuence or):									
	-	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):									
	ecuted and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
8760,	certificate be executed nding physician and use as the burial-transif	al E	rooding in dodn'y East	Due to (or as a consec	(uence or):									
687	he ye	edical		d										
Box (	death certifica attending pt d for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		7-			23d. Date	of delivery				
	ne death the atte	Physiclan/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown		∃Ectopic pregn ☐ Other (specif			Mont	th Day Year				
P.0	that the ed by th detaché	Phys	9 X Unknown											
Vital Records,	sign d be	by	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the u	inderlying caus	e given in Part I	. 23e. Did 1	v	oute to the cause of death?  B Probably 4 Unknown				
900	aw is b	Completed						24a. Was		ere autopsy findings available ior to completion of cause of				
E. B.	The ate h page	Com						perfo	rmed?   de	ath? XiYes 2∐ No				
/ita	Physician: Th rthis certificate ral director, pag	Be (	25. Was case referred to medical examiner?	Mossital.			04	of Death (Check only						
jo	Phys this al dil	2	1 X Yes 2 □ No  27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatier 28b. Time o			rsing Home 5 Resi	dence 6XXOther					
CO	ding After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yeer)	Injury	A M	Injury at Work? 1 ☐ Yes 2 🔯	1 120.1	was Sta	ibbed and cut				
Division	Attending ir death. ector: After by the fune	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At h	iome, farm, sti			28f Location /	Street and Number	r or Rural Route Number,				
Ö	s afte	Certification:	4 Homicide determined	building, etc. (Speci	A+	home		Silver spr	in 1 9000	Louis Ave				
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying Ph: (Check only one) 1 ☐ Certifying Ph: 2 ☐ Medicef Exam	ysicien: To the best of my kniner: On the basis of examination and manner stated	owledge, deat ation and/or in	h occurred at the vestigation, in	he time, date an my opinion, dea	d place, and due to the	cause(s) and man	ner as stated. Id due to the cause(s)				
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Li	cense number		29d. Date signed	(Month, Day, Year)				
	1		I Lung hi	m.D			O.C.M	.E.	March 3	1, 2004				
			30. Name and address of person who dead to the control of the cont	completed cause of death (Ite	m 23a) (Type, 111	Print) Penn S	treet,	Baltimore,	Maryland	21201				
i	Sta Registi	100	31. Date filed (Month, Day, Year) APR 0 5 200	32. Registrar's Sign		Spar								

		ı	For State Registrar	State of Mary		artment of H			giene Reg. No	2006	12757
			Decedent's Name (First, Middle, Last	st)				2. Date of De	ath		3. Time of Death
	Physici		Gloria Jean Hende	rahat				Month	Day 1 30		03:20 A <sup>M</sup>
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Town, or	Location of Dea			County of Death	03.20 A
	Ladiiii	-	9000 Louis Avenue			Silvor	Spring			Monta	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
	Funeral		5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Year	Spring If Under 24 Hrs		th	Montgo 9. Birthr	lace (State or Foreign
	Director		558-78-4512	□M 2덨F 56	Yrs.	Months Days	Hours Min	. (Month, Da		947 Ge	orgia
			Usuel Residence of Decedent	70				Hug. I	- 1	747 00	JIEIU
	ylan Mor		10a. State 10b. County	100	City, Town or Lo	cation				1	0d. Inside City Limits
	Mar B-f-e	ţ	Maryland Montgor	nery	Silver S	Spring					1 ☐ Yes 2 ☑ No
	r 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cour	ntry?
	1 wil		9000 Louis Stree	t		209	01			USA	
	deel F	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No	- 1	14. Race - Americ Black, White,	
စ္	hours after deeth with the Maryland turel', or Items 23e or 28e-f ehow at Everylaer must be notified at		1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give	j	1 ☐ Yes 2፟፟ No	Specify:	to rindari, oto.,			
8	ours rai'.	d by	3 Widowed 4 Divorced	Year or Dates:			- Open, .			Specify: Whit	e
5	2 8 3	Completed	15. Decedent's Ed (Specify only highest gra		(Give	lent's Usual Occupa kind of work done of	furing most of we	nrking	16b. Kir	nd of Business/In	dustry
2	within ene. then	пр	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	)				
2	a filed with Il Hygiene other the		47 Fatharia Nama (Fina Atindia Lana)	2	Nu	rse	40 Mash N-	(Final Asidala		edical	
ī	6 E O S	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden	Sumame)	
Maryland 21215-0036	as 1 and 2 should by the alth and Mante of Health and Mante of the marked for the traumatic error of the traumatic	10	Thern M. Cassel		1		Pauline				
Ja	12 sh n and r ls m		19a. Informant's Name/Relationship (			g Address (Street a					
	tealti	- 1	Brian D. Hendersho  20a. Method of Disposition		5918  Ob. Place of Dispo	Grand Ba				MD 21044 cation - City or To	
0	Pages nent of H		1 ☐ Burial 2 ☑ Cremation 3 ☐	į.	cemetery, cren	natory or other place	e)   Ap1	cil 5,	200. LO	cation - City or To	wn, State
Ë	artment ortant: injury c		* 4 ☐ Donation 5 ☐ Other (Specify	, , , , , , , , , , , , , , , , , , , ,		tan Crema		2004			Virginia
Baltimore,	permit. Pages Department of the Important: If Ite any injury or of once.		21. Signature of Funeral Service Licen	-Cole	F <sup>2</sup> f	Name and Address ancis J. O Univers	Collins sity Blv	Funeral	Hom	e Inc. r Spring	, MD 20901
	4		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the	death. Do not ente	er the mode of dying	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Multiple	1 /	el cuttiv		4			Onset and Death
	/Medical		resulting in death)	Due to (or all a cor			0	50 M = 3			
	Examiner		Commentative first annualistance	h							
-		ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as a cor	nsequence of):						
	cuted	Examin	Cause (Disease or injury that initiated events	c							
Ó,	a exa ian a urial-		resulting in death) Last	Due to (or as a cor	nsequence of):						
8760,	The law requires that the death certificate ba exacuted tie has been signad by the attending physician and tage 2 should ba detached for use as the burial-transit	dicai		d							
9	ntifica ng pl	Med	IF FEMALE:						-10		<del></del>
Вох	eath certific attending p I for use as	hysician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 Live birth 2		Ectopic pregnancy			2	3d. Date of delive Month	
	e dea he at ied fo	SIC	1 ☐ Yes 2 ☐ No	4☐Pregnant at time 9☐Unknown	of death 5	Other (specify)				MOHIII	Day Year
P.0	that the d ad by the detached	Phy	9 Unknown								
	es tha ignad badde	by	Part II. Other significant conditions o	ontributing to death but no	t resulting in the ur	iderlying cause give	en in Part I.		4.	,	e cause of death?
Vital Records,	w requir been si should	ompieted						1 🗆 \	res 2 y	No 3□Prob	ably 4 Unknown
90	law re as be 2 sho	pie						24a. Was autop		24b. Were auto	psy findings available inpletion of cause of
H		Соп						y perfo	rmed? 2 ☐ No	death?	
ita	Physician: The lathis certificate harral diractor, page :	Be (	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o	пе)		
	Physic this ce al dira	70	1 Yes 2 □ No	Hospital: 1   Inpatient	2 🗆 ER/Outpatien	t 3 DOA Othe	er: 4 🗌 Nursing I	dome 5 Resid	lence 6	Other (Specify	SCENE
n of			27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Yee	28b. Time of Injury	28c. Injury Work	at	28d. Describe h	now injury	occurred stabled a	and cut
<u>Ö</u>	Attending r death. ector: After by the fune	ath	2 Accident investigation	3 3	3=17 A		res 2∭No	Sugjeur	Nus :	5 1 2003.00	
Division		tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (Se	pecify)			28f. Location (S City or Tow	Street and m, State)	Number or Rura	Route Number, wise Ave
ā		Certification:			At t	nome		Silver Sir		mD	100
	To the Hospitel or within 24 hours after To the Funaral Director completely filled in	edical		ysician: To the best of my niner: On the basis of exa- and manner stated.							
	ompl	Me	29b. Signature and title of certifier			29c. License	number		29d. Date	signed (Month, i	Day, Year)
)	0		> Lighi.	in. D			O.C.M.1	E. I	March	n 31, 20	04
-			30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)					
_			LING LI. M		111	Penn Str	reet, Ba	ltimore,	Mary	yland 21	201
	Sta Registr		APR 0 5 20	32. Registrar's S		Sporks					

DHMH 17 Rev 1/2001

Registrar

				State of Ma	ryland / Depa			•		
			1 = For State Registrar		-	rtificate of			g. No. 200	4 12759
	Physic	an	1. Decedent's Name (First, Middle, Last,	1				2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Ellen L. Hair  4a. Facility Name (If not institution, give	street and number)		4h City Town o	r Location of Death	March 28	4c. County of De	9:15 a.m.
	Examir	ier	Frederick Memori		a1	Frederi			Frederic	
	Funeral Director		5. Social Security Number 6. Set 241-44-0500	7. Age 7. Age 81	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, August 2,	year) 9. Bi 1922Nort	rthplace (State or Foreign ountry) ch Carolina
	Maryland a-f show	ctor	10a. State 10b. County Maryland Freder	1	10c. City, Town or Lo Valkersvil					10d. Inside City Limits 1 ☐Yes 2 ☐ No
	th with the 23a or 28	al Dire	10e. Street and Number 203 Albany Avenue	, West		10f. Zip Code 217	793	10	g. Citizen of What C	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, it a Medical Examinar investice invilled at Once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	)	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛛 No	ispanic Origin? (Spann, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
215-0	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done of DO NOT use retired	during most of work	ing	6b. Kind of Business	Vindustry
ld 21	illed wi Hygien other th	Be Con	17. Father's Name (First, Middle, Last)		Homema	aker	18. Mother's Name	(First, Middle, Ma	Own home	
ylar	ould be I Menta narked natic ev	To B	Rosker Boykin				Katie Ke			
, Mai	and 2 st satth and 27 is n er traun		19a Informant's Name/Relationship (Ty Henry Hair – husba		203 A	Albany Av	enue, W.,	Walkers	City or Town, State, Ville, Mai	Zip Code) cyland 21793
Baltimore, Maryland 21215-0036	ment of He tant: If iten jury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  `4 ☐ Donation 5 ☐ Other (Specify)		Resthaven Garder	matory or other plac Memorial IS	θ) 4/1/	2004 F	oc. Location - City or	Maryland
Ba	permit Depar Impor any in		21. Signature of Funeral Service Censes  NOVON AMU	ille Gl	//				uneral Hor erick, Mar	
	Physician		23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final	16 cause on each line.		er the mode of dying	g, such as cardiac c	r respiratory arres	t,	Approximate Interval Between Onset and Death
ř	/Medical Examiner		disease or condition resulting in death)	Due to (or as a c	on1a					2 days
4		ner	Sequentially list conditions,		Hip Fract	ure				1 week
<u>,</u>	le be executed ysician and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
68760,	icate be physicia s the bur	cal	d	l						
O	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2   4 ☐ Pregnant at tin 9 ☐ Unknown	☐Fetal death 3☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
α.	es od be	by	Part II. Other significant conditions con	tributing to death but	not resulting in the un	nderlying cause give	on in Part I.			the cause of death?
cor	aw requir s been s 2 should	Completed						24a. Was an	24b. Were at	obably 4 Unknown  itopsy findings available
Vital Records,	iician: The lav certificate has rector, page 2		25. Was case referred to medical						d? prior to death?	completion of cause of 2□ No
	Physician: this certificatal director, I	To Be	examiner?	lospital: 1 🔀 Inpatient	2 ER/Outpatient	t 3 DOA Othe	26. Place of Death		e 6 □Other (Spe	cify)
ono	ding h. After fune	tlon:	27. Manner of Death 1 □ Natoral 5 □ Pending 2 ☑ Accident investigation	28a. Date of Injury (Month, Day Y March 22,		28c. Injury Work		8d. Describe how Fe11	injury occurred	
Division of	I or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, larm, stre	eet, factory, office	2	8f. Location (Stree	et and Number or Ru State)	Mt. Airy,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical Ce	(Check only 2 Medical Examin	Daughte sician: To the best of r her: On the basis of ex	er's house my knowledge, death kamination and/or inv	occurred at the time	e, date and place, a	nd due to the caus	Mary	land
	To the within 2 To the	Med	29b. Signature and title of certifier	and manner stated	d.	29c. License			Date signed (Monti	
			Eludu 7	7		D351	64	4	arch 31,	
	3		30. Name and address of person who con	mpleted cause of deat		Print) West	7th Sho	ot D	lei. Cic, l	10 21701
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's		West	1 000	el He	101,4(,1	W =170
	Registr	ar	APR 0 1	2004	man de	( Control				

			4	artment of Health and Mental Hyg	piene og. No. 2004   2750
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  GEORGE E. HOFFMAN  4a. Facility Name (If not institution, give street and number)  Frederick Memorial Hospital	SR.  2. Date of Death Month March  4b. City, Town, or Location of Death Frederick	th Day Year 24, 2004 1:40 A M  4c. County of Death Frederick
	Funeral Director		5. Social Security Number  217-12-2743  Curve Security Number  6. Sex  1 M 2 D F  80  Yrs.	If Under 1 Year   If Under 24 Hrs. 8. Date of Birth Months   Days   Hours   Min.   May 27,	9. Birthplace (State or Foreign
	the Maryland r 28a-f show notified at	rector	10a. State 10b. County 10c. City, Town or Lo  Maryland Frederick Freder:  10a. Street and Number	ick	10d. Inside City Limits 1 □ Yes ②□ No  0g. Citizen of What Country?
5-0036	be filed within 72 hours after death with the Maryland hal Hygiene. id other than "natural", or items 23e or 28e-1 show event, its Medical Exam har nual be notified at	sted by Funeral Director	1 Never Married 2 Married 1 2 Yes 2 No If Yes, Give Year or Dates:  15. Decedent's Education 16a. Deced	Vas Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2\sum No Specify:	U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry
Maryland 21215-0036	be filed within tal Hygiene. Id other than " event, the Med	To Be Completed	Elementary/Secondary (U-12) College (1-4or 5+)	kind of work done during most of working NO NOT use retired)  L caretaker  18. Mother's Name (First, Middle, N  Ida Danner	Fort Detrick Maiden Sumame)
	and 2 sh lealth and m 27 is m		Catherine Hoffman - Wife 7947	g Address (Street and Number or Aural Route Number, Yellow Springs Road, Frede	erick, Maryland 21702
Baltimore,	permit. Pages 1 Department of H Important: If ite eny injury or ot once.		1 XBurial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22.		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a		Approximate Interval Between
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit.	dicai Examiner	Sequentially list conditions, If any leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		
O. Box 6	that the death certificated by the attending pludetached for use as t	Physician/Med		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
Vital Records, P.	w requires that been signed b should be deta	ompleted by Pł	Part II. Other significant conditions contributing to death but not resulting in the un		acco use conflibute to the cause of death?  s 2 No 3 Probably 4 Unknown  24b. Were autopsy findings available
ital Re		Be Comp	25. Was case referred to medical	autopsy	prior to completion of cause of death?  1 Yes 2 No
Division of V	S S S	Certification: To E	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 FR/Outpatient  27. Manner of Death 1 Natural 5 Pending 2  Accident investigation 3 Suicide 6 Could not be	28c. Injury at Work?  M 1 Yes 2 No	w injury occurred
Divi	o afte		4 Homicide determined 288. Place of Injury - At home, farm, stre building, etc. (Specify)  29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death	City or Town,	, and manner as stated
	To the Hospitel within 24 hours a To the Funerel completely filled	Medical	(Check only one)  2 Medical Examinat: On the basis of examination and/or invane)  29b. Signature and title of certifier	estigation, in my opinion, death occurred at the time, da	te and place, and due to the cause(s)  Id. Date signed (Month, Day, Year)
	10		30. Name and address of person who let d cause of death (Item 23a) (Type, F	D 58371	3-24-04 Exaderial
	Sta Registr		31. Date filed (Month, Day, Year)  MAP 2 9 2004	from 1	m 21701

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2004 ELAINE APR PATRICIA HASEMANN 3 /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) tf Under 1 Year It Under 24 Hrs Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Days Min. 1 □ M 2 X F 108-42-1424 53 25, Director Sep. 1950 New York Usual Residence of Decedent Manyland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Derwood the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 5913 Wild Flower Court USA or Iteme 23a 20855 death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Poices:
IX Yes 2 No
It Yes, Give
Year or Dates:1979-Pres. Pages 1 and 2 should be filed within 72 hours after 1 Never Mamed 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced "netural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical Uniformed Public than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 ie marked other ther eny injury or other traumatic event, III. 5+ Dir. Regulatory Review Officer Health Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Edward Rosicki Elizabeth Golik 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dennis N. Fortin / husband 5913 Wild Flower Ct. Derwood, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 6, 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State \*4 □Donation 5 □ Other (Specify) Arundel Crematory 2004 Odenton, Maryland 21. Signature of Funerat Service Licenses 22. Name and Address of Facility
Going Home Cremation Service once. P.O. Box 784 Bever 201251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition METASTATIC NON SMALL CELL LUNG CANCER **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner S. uentially list conditions. it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. the attending physicien Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deal
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy ō Month Day Year 5 ☐ Other (specify) ☐ Yes 2 XNo detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be 1□Yes 2□No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 □ No 1 Yes 2 No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 XNo ဂ္ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: After 1 XNatural 5 ☐ Pendino 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the I Director: 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospital within 24 hours a: To the Funeral D 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 154231 (MA) 05 Apr 3004 NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 JENNIFER L. CROOK LCDR MC USN egistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 07

2004

			Registrar	State of Marylan	id / Depa	artment of F rtificate of	lealth an Death	R	leg. No.	4 12762		
*	Physici /Medic		1. Decedent's Name (First, Middle, Last)  NADFNE HOS	TETLER				2. Date of Dea Month APR/L	th Day Ye 2 20			
) **	Examir Funeral		4a. Facility Name (If not institution, give st  UNIVERSITY OF W  5. Social Security Number  6. Sec. 10	1ARYLAND 7. Age (In yrs.	last birthday) Yrs.	4b. City, Town, of Record of the Country of the Cou	IMOR	Hrs. 8. Date of Birth (Month, Day	4c. County of D  Baltin  Year)  9.	NOTE Birthplace (State or Foreign Country)		
*	Director	ľ	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ecation		6-5-196	1	Md .		
	death with the Maryland ims 23s or 28s-f ehow	Directo	Md. Somerset  10e. Street and Number	Sno	w Hill	10f. Zip Code		1	l0g. Citizen of What	Yes 2 No		
396	2 should be filed within 72 hours after death with the Marylan and Mental Hygiens and Mental Hygiens is marked other than "natural", or liems 23a or 28a-1 show aumatic event, it a Medical Exam for must be notified at	by Funeral Director	102 Purnell St.  11. Marital Status  12 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 2 No If Yes, Give Year or Dates:	1	21863 Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- perto Rican, etc.)	Black, W	merican Indian, /hite, etc. White		
Maryland 21215-0036	should be filed within 72 hours after ind Mental Hygiene. Inarked other than "natural; or lie umatic event, the Medical Examina	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired are provi	during most of	working	16b. Kind of Busine	ess/Industry		
yland	nould be filed I Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Middle, Last) Harold M. Hostetle				Sylvi.	Name (First, Middle, F a Hostetle	r			
re, M	os 1 and of Health Item 27 other tr		19a. Informant's Name/Relationship (Type Maynard Hostetler, 20a. Method of Disposition XXBurial 2 □Cremation 3 □Re	Brother 200. P	6820		Rd. Sno		d . 21863 20c. Location - City	or Town, State		
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee	Ghu	rch Ger	metery Name an Addre	ss of Facility	-5-04	Snow Hil	1, Md.		
	death certificate be executed  B attending physician and and tor use as the burial-transit	23a. Part1. Enter (the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year		
rds, P.	ires the signed d be de	by	Part II. Other significant conditions conti	ributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.			e to the cause of death?  Probably 4 □Unknown		
r	The ate h page	e Completed	25. Was case referred to medical						y prior t death 1 □ Y			
ō	ling Phys 1. After this uneral dii	To B	examiner?  1 Yes 2 No Ho  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	spital: 1 Inpalient 2   28a. Date of injury (Month, Day Year)	ER/Outpation 28b. Time of Injury	28c. Injun Work	er: 4 ☐ Nursin	Death Check ont one  g Home 5 ☐ Reside  28d. Describe ho	nce 6 □Other (S	pecify)		
=		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At ho building, etc. (Specify	<i>'</i> )			City or Town	, State)	Rural Route Number,		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medicai	29a. Certifier (Check only one)  1 Certifying Physic Check only 2 Medical Examine 29b. Signature and title of certifier	or: On the best of my known: On the basis of examinat and manner stated.	wledge, death tion and/or inv	estigation, in my of	oinion, death o	ccurred at the time, da	ite and place, and d	ue to the cause(s)		
	× × × × × × × × × × × × × × × × × × ×	,	Muchael, S	chlan	2201 (5.	AU417	6435SI		9d. Date signed (Mo	niai, D <b>ay</b> , 1821)		
	Sta Registr	4	30. Name and address of person who com  31. Date filed (Month, Day, Year)	32. Registrar's Signal	-2	-rint)	77110	- 5 F, -!	SVETTER	all elect		

	1 - For State Registrar	State of Maryla	•	rtment of Hea tificate of De		, ,	ene . No. 20 (	04 12763
Physician /Medical Examiner	Decedent's Name (First, Middle, Last)     EMILY  4a. Facility Name (If not institution, give st	L.	HAST	INGS 4b. City, Town, or Loc		2. Date of Death Month 0 3 2	9 200 4c. County of	Death
Funeral Director	212-26-0513	A OFF	MNIF s. last birthday) 7 Yrs.		Jnde 24 Hrs.	B. Date of Birth (Month, Day, Y AY 21, 1	10	Birthplace (State or Foreign Country) MARYLAND
with the Maryland or or 28a-1 show the notified at	Usual Residence of Decedent  10a. State 10b. County  DELAWARE SUSSEX	10c. C	City, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 📉 No
sath with th	RT. 5 BOX 342A	2. Was Decedent Ever in	11 5 12 14	10f. Zip Code 19975	la Origina / Casa		USA	at Country?  American Indian.
1215-0036 within 72 hours after death with the Maryland ene. Then "natural", or items 23a or 28a-f show the Madical Examiner must be notified at mapleted by Funeral Director	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		as Decedent of Hispar Yes, specify Cuban, M ☐ Yes 2 X No Si		can, etc.)		White, etc. WHITE
and 21215-0036 be filed within 72 hours aft that Hygiens and other than "natural", or event, the Madical Exerni Be Completed by F	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Decede (Give k life. D	ent's Usual Occupation ind of work done during O NOT use retired) EDUCATOR	g most of working	16	b. Kind of Busin  EDUCA	,
ba file ba file doth od oth		THOMAS	LEWIS		LUCY		iden Sumame) ISHER	
e, Ma 1 and 2 s Health ar Health ar Health ar Health ar	19a. Informant's Name/Relationship (Type CHARLES W. HASTINGS 20a. Method of Disposition 1	S/SON 20b.	P.O. Place of Dispos	BOX 267, Stion (Name of atory or other place)  LE CEMETER	ELBYVIL]	LE, DELA	WARE 19	975 y or Town, Slate
Baltimol permit. Pages Department of Important: If it any njury or o	21. Sign for of Funeral Service License		22.	Name and Address of	Facility			LE, MARYLAND DELAWARE 1997
Physician /Medical	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the design cause on each line.  Due to (or as a conse	Resp	iratory.	Failure			Approximate Interval Between Onset and Death
8760, ate be executed by the burial-transit burial-transit alical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	Attack	(Street	ke)		- ways
O. Box 6i the death cartific y the attanding p tched for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of preging 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	ital death 3 🗆 E	ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Cords, P wraquires that been signed b should be deta	Part II. Other significant conditions cont	17	esulting in the und	, ,	Part I.		_/	te to the cause of death?  Probably 4 Unknown
Vital Record  Vital Record  ician: The law requir certificate has been si rector, page 2 should I	ASVD					24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior deat	e autopsy findings available to completion of cause of h? Yes 2 \sumbox No
of Vi	27. Manner of Death  1 Matural 5 Pending 2 Accident Investigation	spital: 1 Inpatient 25 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	Other	28	Check only one)  5  Residence  d. Describe how		Specify)
- 595c t	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	city)			City or Town, S	itate)	r Rural Route Number,
To the Hospital of within 24 hours at To the Funeral D completely filled in Medical Ce	(Check only one)  2   Medical Examine one)  29b. Signature and title of certifier	er: On the best of my kr er: On the basis of examinand manner stated.	nation and/or inve	29c. License nun	n, death occurred	at the time, date	and place, and Date signed (M	due to the cause(s)
	30 Name and address of person who com	Dounds v	em 23a) (Type, P	DS5	127	0	3, 29	, 2004 wy, mb; 21804
State Registrar	31. Date filed (Month, Day, Year) MAR 3 1 20	MD Dolan	ARTURA HIJAI	sports	nilford St	Suite 605	-; Salisb	wy, Mb; 21804

Emily Hustings 212 260573

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 4 Decedent's Name (First, Middle, Last) 2. Date of Death 1:42 PM 2004 Hagen, Sr. April Η. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death ROGIONAL Medical 501/56019 VICOMICO ENINSULA If Under 1 Year | If Under 24 Hi 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sax 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months **X**□M 2□ F Days Hours Yrs. 169-18-8556 October 27, 1920 | Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits 1 Yes 2 □ No Virginia Accomack Greenbackville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3560 Captain's Corridor 23356 USA 12. Was Decedent Ever in U.S. Armed Forces?

★□ Yes 2 □ No
If Yes, Give
Year or Dates: Coast 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced White Guard 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 6 Facility Manager National Park Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) August Hagen Helen Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Hagen (son) HCl Box 2100, Tafton, Pennsylvania 18464 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State `4 □Donation 5 □ Other (Specify) St. Catherine's Cemetery April 8, 2004 Moscow, Pennsylvania 21. Signature of Funeral Service Livingee 22. Name and Address of Eacility
Holloway Funeral Home Professional Association rewer 5Cl Snow Hill Road, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia week disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

Physician /Medical Examiner

use as the burial-transit

attending physician

P.0.

Vital

Hospital or Attending

death.

To the Hospital within 24 hours a To the Funeral D

IA

Director:

Examiner

Physician/Medical

þ

Completed

2

permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n any injury or other treun <u>pnce.</u>

**Physician** 

/Medical

Examiner

Directo

Completed by Funeral

**Funeral** 

Director

?7 is marked other than "naturel", or frams 23e or 28e-f show treumatic event, the Medical Examinar must be notified at

2 should be filed within 72 hours after of and Mental Hygiene.
is marked othar than "naturel", or Itar

Baltimore, Maryland 21215-0036

the Maryland

death with

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No 26. Place of Death (Check only one)

25. Was case referred to medical examiner' 1 ☐ Yes 2 XNo 27. Manner of Death

Natural

29a, Certifier

2 Accident

28a. Date of Injury (Month, Day Year) 5 Pending investigation

Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 XNo

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

32. Registra s Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

and address of person who completed cause of death (Item 23a) (Type, Print)

ÀPR 0 6 2004

M.O. 100 €

State Registrar

			1 - For State Registrar	State o	f Marylar		artment rtificate			and M	lental H		ne N201	04	1270	55
	Physici /Medio		1. Decedent's Name (First, Middle, La Kamal George Is	•							2. Date of D Month April		Day 2004	Year	3. Time of De 8:16A	
	Examir		4a. Facility Name (If not institution, give		mber)		4b. City, To			of Death			4c. County			
	Funeral		7109 Fulton Str 5. Social Security Number 6.5	eet Sex	7. Age (In yrs.	last birthday)	Chev If Under 1	Year	lase		8. Date of B	irth	Montg		<u> </u>	oreion
	Director		466-68-5713	1⊠M 2□F	76	6 Yrs.	Months [	Days	Hours	Min.	March	2, Ye	1928	Suda	oface (State or F ntry) 3 N	or orgin
	and		Usual Residence of Decedent  10a. State 10b. County		10c, Ci	ity, Town or Lo	cation							1	0d. Inside City	Limite
	Maryli f sho	ō	Maryland Montgome	12° 17											1√2 Yes 2	
	r 28a-	Directo	10e. Street and Number	:L y	CITE	evy Cha	10f. Zip C	ode				10g.	Citizen of W	Vhat Cour		
	th with	al D	7109 Fulton Stre	et			208	15				Un	ited	State	9.5	
	lams lams	ıner	11. Marital Status	Armed Fo	edent Ever in U		Was Deceder f Yes, specify	nt of His	panic Orig	gin? (Spe	ecify Yes or N		14. Race		an Indian,	
36	s afte	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv	2 XNo		T Yes 2		Specify:	,	, 2.0.,		Specify			
9	2 hour	ted t	15. Decedent's E	Year or D ducation		16a. Deced	dent's Usual (	Occupat	ion			16b	. Kind of Bu	Whi		
215	thin 73	ple	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1	-4or 5+)	(Give	kind of work OO NOT use	done du	ring most	of work	ing					
2	filed within 72 hours after death with the Maryland Hygiene. ythar than "natural", or Itams 23a or 28a-1 show ant, the Mudical Examinat must be motified at	Completed		5+		Path	nologi	st				M	edici	ne/Pa	tholog	У
Maryland 21215-0036	htal H	Be	17. Father's Name (First, Middle, Last	)				1			(First, Middle	e, Maio	len Sumam	e)		
Ž	thould id Mei mark matic	은	George Ishak  19a. Informant's Name/Relationship (	Type Print)		19h Mailin	a Address (9	Street as			latouk ul Route Numi	hor Cit	h. or Tour	Ctata Zia	Codel	
Ma	nd 2 : alth ar 27 is ir trau		Margaret Rose Isl	*	hter						, Silv					
ore,	of Hee		20a. Method of Disposition 1 Durial 2 Cremation 3 D		20b. F	Place of Dispo	sition /Nama	of	1		ate		Location -			-
Ĕ	Page ment ant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of Co		State Mo	ntgomer ntgomer emator	lum. In	ıc.	20	004		Be	thesd	a. Ma	aryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic event, its Medical Eventuer must be notified at once.		21. Signature of Funeral Service Lice	Serie	. мо	0803 Be	Name and Acthesda thesda thesda	Address A-Ch	of Facility evy [arv]	, Rob Chas and	ert A. e, Inc 20814	Pu	mphre	y Fur iscor	neral Ho nsin Ave	ome/ enue
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cone cause on e	aused the deat	th. Do not ente	er the mode o	of dying,	such as o	cardiac c	or respiratory a	arrest,			Approximate Interval Betwee	en
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	/Medical Examiner		f and a sum of the sum		or as a conseq											
		Jer	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Left	Ventr	uunga of):	нурег	rop	hy					4	Years	
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c												
8760,	cate be executed physician and the burial-transit	al E	resulting in dealiny East	Due to (	or as a conseq	luence of):										
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Вох	leath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic pregi						23d. Date	of delive	ry	
о. П	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ant at time of d		Other (speci						Mon	th	Day Yea	r
مز	res that the de signed by the a be detached t	y Ph	Part II. Other significant conditions of	ontributing to de	eath but not res	ulting in the ur	derlying caus	e given	in Part I.		23e. Did	tobacce	o use contri	bute to the	e cause of deat	h?
Vital Records,	w requires been sign should be										1 🗆	Yes	2 □ No :	3 <b>X</b> Proba	ably 4 DUnkr	nown
eco	e law re has bec	Completed						_			24a. Was		24b. W	ere autop	sy findings ava	ilable
		Соп									perfe	ormed?		eath?	pletion of causi	6 01
VIII VIII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:							Check onl					
o	Phys this ral di	. To	1 X Yes 2 No 27. Manner of Death	1	npatient 2	ER/Outpatient 28b. Time of		Other:	4 L INUIS		ne 5X Resi				)	
ion	Attending Is death.	atlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		of Injury h, Day Year)	Infury	М	Injury a Work? 1 🔲 Ye	s 2 🗆 N				iar) occurro			
Division of	or Attendated after death Director:	Certification:	3 Suicide 6 Could not b	28e. Place	of Injury - At ho	ome, farm, stre	et, factory, of	fice		2	8f. Location ( City or To			r or Rural	Route Number,	
	pitel or ours afte aral Dir		COn Consider the Consider Ph										,			
	b the Hospitel thin 24 hours a tha Funaral I empletely filled	ledical	29a. Certifier 1 X Certifying Ph (Check only one) 2 ☐ Medicel Exam	niner: On the ba and manr	isis of examina	tion and/or inv	occurred at t estigation, in	he time, my opir	date and lion, death	place, a	and due to the ad at the time,	date a	(s) and man ind place, ar	ner as sta nd due to	the cause(s)	
6	on the complex	Σ	29b. Signature and title of certifier	15.	4		29c. Li	cense r	number			29d. D	ate signed	(Month, E	ay, Year)	
6	(v	-	30. Name and address of parson into	completed early	of dooth /fr	22a) (Tr 1		000	<u> 25559</u>	)		Apr	cil 6,	200	4	
			30. Name and address of person who Cesar Rudzki, M.		5 19th			. #	407.	Wast	ingtor	1. Г	) <b>.</b> C .	2003	6	
	Sta	-	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa							- , L		2005	<u> </u>	
	Registra	ar	APR 07 20	U4 A	eneral	P	Spar	Kal								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Anna Louise Ingram 2004 April 6:45 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Northampton Manor Healthcare Center Frederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (Stete or Foreign Country) **Funeral** Days 1 □ M 283(F 75 Director 215-26-8449 17.1928 Maryland Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or itams 23a or 28a-f show 10c. City, Town or Location 10a Stete 10b. County 10d. Inside City Limits 1⊠ Yes 2□No Directo Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 609 Himes Ave. #102 21703 Be Completed by Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Andrew Hobbs (unobtainable) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne Burge / Daughter 609 Himes Ave. #101, Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date April 5. 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 6 any injury o 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens 2004 Frederick, Maryland 21. Signature of Funeral Service Licenses Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner attending physician and for use es the bunal-transit Hospital or Attanding Physician: The law requires that tha death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2/2 No 1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 1 Yes 2 No 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Dey Year) edical Certification: 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide temporary Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date/signed (Manth, Day, Year) 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar

APR 0 2 2004

Hope McIntyre, M.D.

31. Dete filed (Month, Day, Year)

32. Registrar's Signature

Main 5%.

1502

3

Suite 202

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 9:07P M Ida MAe Joyner 03 04 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 24 Hrs. If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Min. 1 M 2 F 90 218-24-1058 Saluda, S.C. Director 25 13 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mantal Hygiene.
and if Health and Mantal Hygiene.
and if Health and East other then "natural", or items 23e or 28a-f show they or other freumatic event, ite Macter East item must be notified at 28a-f show D.C. Washington 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1006 I Street N.E. 20002 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coftege (1-4or 5+) 12th. Self Employed Housekeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Wilson Carey Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4724 6th. Place N.E. Washington, D.C. Irene Kelsey Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of the Important: If its eny injury or ot one one. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4-10-04 Brentwood, MD. Ft. Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee Marshall 4217 9th. St. N.W. Washington, D.C. 20011 23a. Pany. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition Sepsis **Physician** 3 days resulting in death) /Medical Due to (or as a consequence of): Examiner 3 days Pneumonia Sequentially list conditions, Physician/Medical Examiner Due to for as a consequence of it any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit 3 days Urinary Tract Infection and Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by cate has been signated bage 2 should b 1 Yes 2 No 3 Probably 4X Unknown Cerebro Vascular Accident 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Renal INsufficiency autopsy performed? 2€ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospitel or Attending within 24 hours after death.
To the Funerel Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature) and title of certifier ress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) .
APR 0 9 2004 istrar's Signature State Registrar

			1 - For State Registrar	State of M	aryland	d / Depa	artment of F	lealth a		Re	g. No.	04	127	
2	Physici	an	1. Decedent's Name (First, Middle, Las.							Date of Death Month	Day	Year	3. Time of	
	/Medic		Robert Sumr							pril	6 20	004	6:00	АМ
	Examin	er	4a. Fecility Name (If not institution, give				4b. City, Town, o		of Death		,			
	<b>-</b>		Shady Grove Adver  5. Social Security Number 6. Se			ast birthday)	Rockv			Date of Birth	Montg	9. Birth	plece (State o	r Foreian
	Funeral Director			XM 2□F	80	Yrs.	Months Days	Hours	Min.	(Month, Day, rch 5,	Year) 1924	Cou Mary	ntry)	
	D.		Usuel Residence of Decedent											
	arylar ahow	_	10a. State 10b. County			, Town or Lo							10d. Inside Cit 1 ☐ Yes	
	8a-f.	Director	Maryland Montgome	ry	(	Gaithe	rsburg			1 40		15		
	with t	Dir	10e. Street and Number				10f. Zip Code	70			g. Citizen of t		•	
	eath	Funeral	12225 Bradbury Dri	12. Was Decedent	Ever in U.S	S. 13.	208 Was Decedent of H		igin? (Specify		Jnited 14. Rad		es Indian.	
(0	r Hen	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯	,		Was Decedent of I			an, etc.)		ck, White,		
8	hours after death with the Maryland tural', or flems 23a or 28a-f ahow al Exartinet must be notified at	\$ by	3 ☐ Widowed 4 反 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☑ No	Specify:			Specify	v: Whi	.te	
5-0	72	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during mos	at of working	1	6b. Kind of B	usiness/Ir	idustry	
12	within sne. than	ldmi	Elementary/Secondary (0-12)	College (1-4or 5	5+)		matical :			n T	I C C		mont	
d 2	The state of the s	e Co	17. Father's Name (First, Middle, Last)	JT		Mathe	matical			irst, Middle, M	J.S. Go laiden Suman		ment	
an	0 0 0 0	o Be	Ernest Johnson					Mai	ry Edn:	a Garre	o++			
Maryland 21215-0036	2 should and Men Is marke aumatic	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address (Street					State, Zij	Code)	
Σ	es 1 and 2 should of Health and Mer item 27 Is marke r other traumatic		Judith A. Compto	n/Niece			Bradbur	y Driv	ve, Ga	ithers	ourg, M	iary1	and 20	878
ore	of He		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	ce	emetery, crei	sition (Name of matory or other pla	ce) [	April 9	9.	0c. Location -	City or T	own, State	
Ë	Pages ment of I		*4 □Donation 5 □ Other (Specify	)	Cre	emator	nery ium, Inc	.   2	2004	В	Sethesd	a, M	aryland	1
Baltimore,	permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service Licen:		140104	Ro	Name and Address ckville,	ss of Facili	™Robert 300 W	t A. Pu Lest Mo	ımphrey ntgome	ry Fun	eral H venue	ome/
	40340		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	M0135 d the death ine.							-	Approximate Interval Betv	veen
	Physician		Immediate Cause (Final disease or condition	Sep	Sis							1	Onset and D	
	/Medical Examiner		resulting in death)	Due to (or as			. 0	4						
	LAditilite	<u>_</u>	Sequentially list conditions,	b. Due to (or as			infecto	7				(	unkno	1Wn
	pet nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire Underlying Cause (Disease or injury	Due to (01 23	a c psequ	ierice orj.								
	execunand and all-tra	Exal	that initiated events resulting in death) Last	Due to (or as	a consequ	ience of):						-		
68760,	ate be executed obysicien and the burial-transit	Icail		d								- 1		
68	The law requires that the death certificate be executed ate been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Aedi	ie centrie											
Вох	leath certific attending p	Physician/Med	23b. was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	у				te of deliv	,	
	at the dea by the at tached fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□ Unknown	t time of de		Other (specify)	*			Mo	nth	Day Y	ear
P.0	hat the deby		Part II, Other significant conditions co	entributing to death t	out not resu	ulting in the u	nderlying cause giv	en in Part I	-	23e. Did toba	acco usa cont	ribute to t	he cause of de	eath?
Records,	uires that signed t d be det	d by	Pneumonia	This could be a section of			indonying oddoo gi			1 Tes	2.5		pably 4 □U	
OC	v requir been s should	lete	7,1000							24a. Was an		Mara auto	ppsy findings a	wallahla
Re	The lav	Completed								autopsy perform	ed?	prior to co death?	mpletion of ca	use of
Vital		e C	25. Was case referred to medical					26 Place	of Death (C	1 ☐ Yes 2 heck only one		I □ Yes	2□ No	
Ξ	Physician: this certificanal director,	0 B	examiner? .	Hospital: 1 Apatie	ent 2 🗆 E	ER/Outpatier	nt 3 DOA Ott			5 Residen		er (Specil	٠ الم	
u of		n: T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry iy Year)	28b. Time o		ry at		Describe hov			,	
Sio	en eat or:	catic	2 Accident investigation					Yes 2	No					
Division	after de Direct	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	jury - At ho tc. <i>(Specify</i>	me, farm, str	eet, factory, office		28f.	Location (Stre City or Town,		er or Rura	al Route Numb	er,
_	spital ours a neral filled		29a. Certifier X Certifying Phy	/sician: To the best	of my know	wledge, deat	occurred at the ti	me. date an	nd place, and	due to the cau	use(s) and ma	nner as s	tated.	
	To the Hospital within 24 hours a To the Funeral completely filled	Medicai	(Check only 2 Medical Exem	iner: On the basis o and manner st	of examinat	ion and/or in	vestigation, in my o	opinion, đea	ith occurred a	t the time, dat	e and place,	and due to	the cause(s)	
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Σ	29b. Signature and title of certifier				29c. Licens				d. Date signe		-	
	10		Cristinbarker	Howe mi	n		Duos	5981	(	C	yri16.	, 20	04	
	1		30. Name and address of person who o	ompleted cause of c	death (Item	23a) (Type,	Print)	10 0.	challe	10-0-1	اء ، ه			
		10	Cristin Parker How	32. ₽eqisti	rar's Signat	ture •	-cher w iv	C 70	centre	inaryla	10131			
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 9 200	4 Some	مهمر	19	Sparks	1						

			1 - For Stata Registrar			partment d ertificate	of Health and I		iene	 4 12769
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, La     N A H M U D U L  4a. Facility Name (If not institution, give	н.	JAMAL		vn, or Location of Deatl	2. Date of Death Month		1 /33 A M
	Funeral Director		5. Social Security Number 6. S 2 1 5 - 3 1 - 3 5 1 2	7. Age (X) M 2 F 6	In yrs. last birthda	y) If Under 1 Y	ear If Under 24 Hrs. ays Hours Min.		None	Birthplace (State or Foreign Country) angladesh
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ant, the Modical Extering must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland  10e. Street and Number	None	Oc. City, Town or	timore				10d. Inside City Limits 1 XYes 2 No
	ours after death with the Marylan rat', or Items 23a or 28a-f show Examiner must be notified at	Funeral Dl	2120 Chantill  11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	2 1 2 3. Was Decedent If Yes, specify (			Banglad  14. Race - A  Black, W	esh merican Indian,
5-0036	within 72 hours after ene. than "natural", or li	by	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gra	1 ☐ Yes 2 🖄 No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢	No Specify: ccupation one during most of work		Specify:	Asian
nd 2121	a filed within 72 ho It Hygiene. other than "natur	e Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last,	5 College (1-4or 5+)	Ass	t. Libi	rarian	ne (First, Middle, M		Library
Marylar	12 should be h and Menta 7 le marked traumatic ev	ToB	19a. Informant's Name/Relationship (				Jahana reet and Number or Ru	ra Begu ral Route Number,	M City or Town, State	e, Zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed wind Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the once.		Nina Jamaly - 1  20a. Method of Disposition  1XD Burial 2 Cremation 3 C  4 Donation 5 Other (Specification)	Removal from State	<ol> <li>Place of Dis cemetery, cr</li> </ol>	position (Name or rematory or other Cemete	tilla Rd, f <sub>place)</sub> ery 4-9-	Date 2	0c. Location - City	21228 or Town, State ngladesh
Balt	permit. Departi		21. Signature of Funeral Service Licer  Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q	Mala		411Kenr	nedy St,N	.W.,Was	hington	
•	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	clero		ordio vasi			Approximate Interval Between Onset and Death 20 y ews
,8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
La Sox 6	res that the death certifics igned by the attending ph be detached for use as t	Physician/Med	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3	☐Ectopic pregna			23d. Date of d Month	lelivery Day Year
Records, P	requi	by	Part II. Other significant conditions of	valve F			given in Part I.	23e. Did toba 1 ☐ Yes	<b>A</b>	to the cause of death?  Probably 4 □Unknown
Made ital Rec	The la ate has page 2	se Completed	25. Was case referred to medical				26 Place of Deat	24a. Was an autopsy performe 1 Yes 2	prior to death?	autopsy findings available completion of cause of
13,₽	ding Physician: n. After this certific funeral director,	on: To B	27. Manner of Death	Hospital: 1 Inpatient  28a. Date of Injury (Month, Day Ye	2 KER/Outpation 28b. Time Injury	BIIL SLI DOA	Other: 4 Nursing Ho	ime 5 Residence 28d. Describe how		ecily)
Division	death ctor: / the	Certification	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, s	M 1	☐Yes 2☐No	28f. Location (Stree City or Town, S	et and Number or I State)	Rural Route Number,
, ,	To the Hospital or A within 24 hours after To the Funeral Directon pletely filled in by	edical (	29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of m iner: On the basis of exa and manner stated.	amination and/or i	ith occurred at the nvestigation, in m	e time, date and place, by opinion, death occurr	and due to the caused at the time, date	se(s) and manner a a and place, and du	as stated. le to the cause(s)
	with To t	Σ	29b. Signature and title of certifier	hlas	<i>—</i> "		onse number	_ /	Date signed (Mor	
	~		11 1	ompleted cause of death		SA A	nes Ho	spital	Bula	2004 Somere my
	Stat Registra	te ar	31. Date filed (Month, Day Year) APR 06 200	32. Registrar's	ignature &	Sour	Si .	1	12000	

			1 - For State Registrar	State of Maryland		artment of H			ne No. 2004	12770
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia		ANTHONY	ALONZO	т.	ACKSON		Month Mar 2	Day Year 2004	9:00P <sup>M</sup>
	/Medic		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deat		4c County of Death	
	Examin	er	Washington Adv		+ = 1		ma Park		MONTGON	
79			5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year	If Under 24 Hrs			
	Funeral Director			M 2□F 52	Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day, You Oct. 23	9ar) Cou	place (State or Foreign intry) arvland
			Usual Residence of Decedent	54				000.23,	1501 110	i: yrano
	/land	i	10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary	to	MD Montgo	nory Si	1,702	Spring				1 <b>⊠ 1%</b> s 2 ∐ No
	the 288	rec	10e. Street and Number	IICT A DT	TACT	10f. Zip Code		10g	. Citizen of What Cou	ntry?
	3a o	Funeral Director	1185 Good Hope	Road		2	0905		11.5	S.A.
	ms 2	era		2. Was Decedent Ever in U.S.	13.	Was Decedent of H f Yes, specify Cuba		Specify Yes or No-	14. Race - Ameri	can Indian,
S	or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				to Hican, etc.)	Black, White	
ලි	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-f show the Medical Examiner must be notified at	by	3 ØWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 <sup>N</sup> No	Specify:		Specify: B]	ack
21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usual Occupa	ation	16i	b. Kind of Business/Ir	ndustry
7	thin 7	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)	, king	PRIVATE	C
7	er th	6	12th		Con	tractor				
p	al Hy al Hy I oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma	iden Sumame)	
<u>a</u>	uld b Ment wrkec	2	Willie M. J.	ackson			Clar	stine	Small	
Maryland	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ic 8	19a. Informant's Name/Relationship (Type			-		ural Route Number, C		
Σ	and 2 alith 27 i		Marsha Jackson-	Sister	409	N Robi	nson St	: Baltimo	re, MD 2	21224
Baltimore,	of He of He item		20a. Method of Disposition	com	ce of Dispo	sition (Name of matory or other place	e)	Date 200	c. Location - City or T	own, State
Ĕ	Page III		1 ☐ Burial 2 【Cremation 3 ☐ Ri 1 ☐ Donation 5 ☐ Other (Specify)	Met	rg,F	url Svc	$s. \mid 4/3$	3/2004 A	lexandri	a, VA
ä	mit.		21. Signature 17 u eral Service License	- 4				nowden F		
m	P P P P P		Lleage	1. Hugue	ary	246 N.	Washing	gton St F	ockville	,MD20850
	Physician /Medical Examiner		23a. Pert1. Enter the disease, o complice shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	Pheumo Due to (or as a consequent	nce of):					Approximate Interval Between Onset and Death
8760,	ate be executed physician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	nce of).	100-2	) { f-1 a ~	NCY SY	NOREME	
9	g ph as th									
P.O. Box	that the death certifica ted by the attending ph detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal di 4 ☐ Pregnant at time of deal 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
	Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detache	4 /	Part II. Other significant conditions con	ributing to death but not resulti	ing in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
ds	86 20 90	d by	DEHYDRATIO	J				1 ☐ Yes	2□No 3□Prol	bably 4 Inknown
Ö	requ	Completed						- 11	100.00	
36	has has	m jd	LUNAL INSK	FRICIENCY				24a. Was an autopsy performed	prior to co	opsy findings available empletion of cause of
<u></u>	cate							1 ☐ Yes 2 🗵		\$100
<u> </u>	ician Sertifi ector	Be	25. Was case referred to medical examiner?	ospital:		Othe		ath (Check only one)		-
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ב	ding Physician: The law requir h. After this certificate has been si funeral director, page 2 should	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	Work		28d. Describe how	injury occurred	
Division of Vital Records,	Attending ir death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No			
$\geq$	l or Attence after death Director: I in by the	iii.	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Run itate)	al Route Number,
	urs al							1		
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: Completely filled in by the	edical	(Check only 2 Medical Examin	cian: To the best of my knowledge: On the basis of examination	edge, death n and/or in	occurred at the time vestigation, in my or	ne, date and place pinion, death occi	e, and due to the caus urred at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
	the hin 2 the I	Med	one)	and manner stated.						
	C TE O	«	29b. Signature and title of certifier	1		29c. License			Date signed (Month,	
7	10		Marasha ho	myheis			31910	<del></del>	3/30/01	
	•		30. Name and address of person who cou	npleted cause of death (Item 2	3a) (Type.	Print) CARNO	LAVE	# 360 Mb	7. TAKO	MAPK
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 200	32. Registrar's Signatur		Some V				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #10a-1 & 17 State of Maryland / Department of Health and Mental Hygiene
AMEND TIEM #1 PER FIN 6831 5/03/04 JR
AMEND #5perINF4/15/04 BWW.McCo Certificate of Death Reg. No. For State Registrar AMEND #5per:INF4/15/04, PM, MCC 2. Date of Death 1. Decedent's Name (First, Middle, Last) RUTH RTEGEL JACOBS 27<sup>Pay</sup> 12:03 M 2004 Year Month MAR **Physician** RIEGAL JACOBS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA r If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5-Social Security Number 139-18-7984 --164-18-4825 **Funeral** Days Min. Hours 1 ☐ M 2 🗓 F Months Director 82 Jun 30, 1921 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Engineer must be notified at VA **FAIRFAX** 1 ☐ Yes 2 No **Funeral Director FATRFAX** CA Truckee 10e. Street and Number UK ROAD 10f. Zip Code 10g. Citizen of What Country? 9211 CLENBROOK P.O. BOX 944 <del>96162</del> 22031 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Completed by 3

☐ Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN RIEGEL John Riegal 흔 Margaret Sutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall S. Jacobs/Son P.O. Box 9445, Truckee, CA 96162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National May 4, 2004 Arlington, VA 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityHines-Rinaldi Funeral Home llan 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Pert1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** SEPSIS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy detached for Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, å 1 🗌 Yes 2X No 3 ☐ Probably 4 ☐ Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1□XYes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes 2 ☐ No ÷ 3 DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 XNatural 2 ☐ Accident 5 Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pellij within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 03, 30, 2004 D56305 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600 KEVI L. CHRISTOPHER LCDR MC 31. Date filed (Month, Day, Year)
APR 0 5 2004 32. Registrar's Signature State Registrar

			1 - For State Registrar	State	of Maryla		artment of F				Reg. No. 2	2004	12772
	Physici /Medic		1. Decedent's Name (First, Middle BERTIE BALTIMOR							2. Date of De Month March	26, 2	2004 2004	3. Time of Death
	Examir		4e. Fecility Name (If not institution	•			4b. City, Town, o					unty of Death	
			Mallard Bay Nur  5. Social Security Number	sing and		Center rs. last birthday)	Cambri			O Data of Bird		cheste	
	Funeral Director		219-07-9795	1 ☐ M 2 ☐ F	98	Yrs.	Months Days	Hours	Min.	8. Date of Bird (Month, Da 11-6-	y, Year)		place (State or Foreign ntry)
			Usual Residence of Decedent		140								
	show	2	10a. State 10b. County			City, Town or Lo	ocation					1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Director	MD DORCH	IESTER	V	/IENNA	10f. Zip Code				10a Citizen	of What Cour	
	3a or	0	4817 OLD RT. 5	50			21869				USA		,
	ems 2	Funeral	11. Marital Status		edent Ever in	U.S. 13.	Was Decedent of H	lispanic Orig	gin? (Spec	cify Yes or No	- 14.	Race - Americ Black, White,	
20	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show the Medical Exameter niust be positived at	by Fu	1 ☐ Never Married 2 ☐ Marr 3 🎽 Widowed 4 ☐ Divorced	ied 1 🗀 Yes If Yes, G	2 ₩ No ive		1 ☐ Yes 2 ☑ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	, 0.0.,			O-AMERICAN
215-0036	ture!	ed b	15. Deceden		Dates:	16a. Dece	dent's Usual Occup	ation			16b Kind o	of Business/Inc	dustry
C   2	hin 72 s. in "ns Medic	plet	(Specify only highes Elementary/Secondary (0-12)	t grade completed)	1-4or 5+)	(Give	kind of work done DO NOT use retired	during most d)	of working	g			,
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land	bed la be	Be	17. Father's Name (First, Middle,				100			(First, Middle,	Meiden Sur	name)	
$\geq$	should nd Men marke umatic	10	LEVIN BALTIMORE  19a. Informant's Name/Relations			19h Maili	ng Address (Street			OLLEY	or City or To	um State Zin	Code
Mar	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	1	EUNICE JONES/DA				OLD RT.5					wii, State, Zip	C008)
re,	item other		20a. Method of Disposition			. Place of Dispo	osition (Name of matory or other place	(a)	Da	ite	20c. Locati	on - City or To	wn, Stete
Ē	Pages nent of ent: if it ury or o		1 Burial 2 ☐ Cremation  1 Donation 5 ☐ Other (S				OWN CH. C	1 .	-02-04	i	EAST	NEW MA	RKET, MD.
Baitimore,	permit. Pages Department of I Importent: If it any injury or o		21. Signature of Buneral Service	Licensee Ava	Men		2. Name and Address		JOL			CHAPE	L
ŧ			23a. Part1. Enter the disease, or shock, of heart failure. List	complications that	caused the de		-					1001	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	ATher	·	fic hec	est c	do'se	easi			Onset and Death
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ZOX	leath certifica attending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou							23d.	Date of delive	rv
Ď	0 00 0	icia	in the past 12 months? 1 Yes 2 No	4☐Preg	birth 2 ☐ Fe nant at time of		Ectopic pregnancy Other (specify)	1				Month	Day Year
r D	at the d by th stache	Phys	9 🗆 Unknown	9□ Unkr									
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VItal	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?						of Death (	Check only o			
0	hys this	2	1 Yes 2 No 27. Manner of Death			ER/Outpatier		4 LANUI				Other (Specify	)
VISION	ling After une	ertification;	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investig	ation	of Injury oth, Day Year)	28b. Time of Injury	Worl	yat k? Yes 2 ☐ N		ld. Describe h	low injury oc	currea	
Ž	in Title	Certific	3 ☐ Suicide 6 ☐ Could a 4 ☐ Homicide determ	ined 286. Place	e of Injury - At ling, etc. (Spe	home, farm, str cify)	eet, factory, office		28	Bf. Location (S City or Tow		imber or Rura.	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the Examiner: On the b and mar	e best of my k basis of exami oner stated.	nowledge, death nation and/or in	n occurred at the time vestigation, in my of	ne, date and pinion, deat	d place, an	d due to the of at the time, o	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)
	To th To th compl	Me	29b. Signature and title orcertifier				29c. License	number	59	2	29d. Date sig	ned (Month, L	Day, Year)
	6	10	30. Name and address of person		se of death (It	em 23a) (Type,	Print)	A (	27	(ami	וחומו	IF D	DD-21617
y	Sta		31. Date filed (Month, Day, Year) APR 0	2004 32.5	Registrar's Sig		More #	61	/ (	29/00/2	very	10	10-116/3
4	Registr	rar	APR U	- 2004		~	More						

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Registrar

	-	For State Registrar	Sta	ate of M	aryland		artment <i>tificate</i>			and M	ental Hy	/gie Reg.	20	04	12	774
		Decedent's Name (First, Midd	le, Last)								2. Date of D Month		Day	Y <i>e</i> ar	3. Time of	Death
Physici		Pauline	Este	elle		Kess	elrin	g		Ì	March		, 2004		5:00	P M
/Medic Examir		4a. Facility Name (If not institution	n, give street	and number)			4b. City,	Town, or	Location o	f Death			4c. County	of Death		
		147 King St.					Hag	erst	own				Washir	ngton		
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2			st birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth ay, Ye	ear)	9. Birthp	ace (State o	r Foreign
Director		220-09-7698	1 M 2	2011	85	Yrs.					Oct. 2			Virg		
pur *	-	Usual Residence of Decedent  10a. State 10b. County	,		10c. City	. Town or Lo	cation							11	Od. Inside Ci	ty Limits
sho	5	MD Washi			Ио от	orator									1 🔯 Yes	2 🗆 No
the A 288-1	ect	10e. Street and Number	igcon		nage	erstow	10f. Zip	Code				10a.	Citizen of W	Vhat Coun	trv?	
with	ā	147 King St.						L740				_	U.S.A		•	
1215-0036 within 72 hours after death with the Maryland ene. ene. than 'natural', or items 23a or 28a-1 show the Medical Examinar is use to indiffed at	Funeral Director	11. Marital Status	12. W	as Decedent	Ever in U.S	S. 13. 1	Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or N		14. Race	e - Americ		
fer d	필	1 ☐ Never Married 2 ☐ Ma	rried 1	rmed Forces? □ Yes 2 🔀		1				, Puerto	Rican, etc.)			k, White,	∍tc.	
03(	þ	3 X Widowed 4 ☐ Divorce	4 Y	Yes, Give ear or Dates:			1 ☐ Yes 2	NO NO	Specify:				Specify	Whi	te	
21215-0036 od within 72 hours aff gjene. or then "naturel", or the Wedteal Exam	Completed	15. Decede (Specify only high	nt's Education	n nnieted)		(Give	dent's Usua kind of wor	k done a	uring most	t of worki	na	168	. Kind of Bu	siness/Inc	lustry	
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be fill that the plant of out	Be	17. Father's Name (First, Middle Grover Brown	, Last)								Kirby	e, mai	den Sumam	θ)		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Imperatment of Health and Mental Hygiene. Imperatment I fram 271s marked other than "natural", or Nems 23a or 28a-1 show any injury or other traumatic event, the Medical Examination with the indiffice at once.	2					40h 14-10		/Chrond o			I Route Numi	har C	h. a. Taum	Ctata 7i-	Cadal	
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DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	(Check only 2 Medice one)			of examinat		vestigation,	in my or	oinion, dea			, date	and place, a	and due to	the cause(s	)
To the within 2 To the complet	Σ	29b. Signature and title of certif	er		1. 1.	. ) .			567	187			Date signed			
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54			tz, MI		1110	Medic	al Car		Dr.,	Hag	erstow	n,	MD	21740	)	
St Regist	ate rar	31. Date filed (Month, Pay, Yea	6 2004	32. Fegist	rar's Signal	J. Aj	ness									

			1 - State Registrar C	partment of Health and Mertificate of Death	Reg	ene . No 2001	12775
П	Physici		1. Decedent's Name (First, Middle, Last)  John Raymond KERSHNER		2. Date of Death Month March 22	2, 2004 Year	3. Time of Death
}	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Н	Funeral		479 Antietam Drive  5. Social Security Number  6. Sex, 7. Age (In yrs. last birthda	Hagerstown  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Washin 9. Birthol	Gton ace (State or Foreign try)
	Funeral Director		5. Social Security Number 6. Sex 120-09-7813 7. Age (In yrs. last birthde 85 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y May 19,	ear) Coun 1918 Mar	yland
	yland		10a. State 10b. County 10c. City, Town or	Location		10	Od. Inside City Limits
	Ba-f st	ctor		agerstown			1 ☐Xes 2 ☐ No
	with the	Funeral Director	10e. Street and Number 479 Antietam Drive	10f. Zip Code 21740	10g	. Citizen of What Coun	try? SA
	ems 2:	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Amged Forces?	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America	an Indian,
36	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show solical Extribitor raist be netitied at	by Fu	1 Never Married 2 Married 1 X s 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates: 1944-45	1 ☐ Yes 2 ☐ Xo Specify:	riicari, etc.,	Black, White, e	nite
2-0	72 hou	eted	15. Decedent's Education 16a. Dec	cedent's Usual Occupation ve kind of work done during most of worki DO NOT use retired)	ing 168	b. Kind of Business/Ind	ustry
121	within ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)  welder		manufa	cturing
1d 2	e filed within al Hygiene. other than vent, tr.e Ms	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	den Sumame)	ctaring
Maryland 21215-0036	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other than other traumatic event, ILa M	70 E	Fred Ellsworth Kershner		S. Clar		
Mar	nd 2 sh ith and 27 is rr ' traum			illing Address (Street and Number or Rura Antietam Dr., Hag			
ore,	es 1 ar of Hea fitem ?					c. Location - City or Tov	
Baltimore,	permit. Pages Department of the Important: If ite any injury or of		'4 □ Donation 5 □ Other (Specify) Cedar L	_awn Mem.Park 3/2		lagerstown	
Bal	permit Depar Impor any in	y s	21. Signature of Funeral Service Licensee	22. Name and Address of Facility 1415 E. Wilson Blvd.		FUNERAL town, Md.	
I	Fny <del>sicia</del> n /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	nter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
8760,	death certificate be executed XB eatlending physician and But of tor use as the burial-transit of	lical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):	rtension			
P.O. Box 68	death certifii e attending p od tor use as	Physician/Med		B □Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year
	se Ped	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the	
Division of Vital Records,	: The law requ cate has been page 2 shoulk	Completed			24a. Was an autopsy performad	prior to com death?	sy findings available pletion of cause of
Vita	Physician: Th this certificate ral director, pag	) Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outbati	26. Place of Death	-		
on of	Attending Phys ir death. ector: After this by the funeral di	tion: To	1 ☐ Yes 2 ☐ Mo  27. Manner of Déath 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation  1 ☐ Accident investigation  1 ☐ Inpatient 2 ☐ ER/Outpati 2 ☐ Accident 2 ☐ ER/Outpati 2 ☐ Accident 2 ☐ ER/Outpati 2 ☐ Accident 2 ☐ ER/Outpati 2 ☐ Accident 2 ☐ ER/Outpati 2 ☐ Accident 2 ☐ ER/Outpati 2 ☐ Accident 2 ☐ ER/Outpati 2 ☐ ER/Outpati 2 ☐ ER/Outpati 2 ☐ ER/Outpati 2 ☐ ER/Outpati 2 ☐ ER/Outpati 2 ☐ ER/Outpati 2 ☐ ER/Outpati 2 ☐ ER/Outpati 2 ☐ ER/Outpati 3 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 5 ☐ Pending 5 ☐ ER/Outpati 6 ☐ ER/Outpati 6 ☐ ER/Outpati 7 ☐ ER/Outpati 7 ☐ ER/Outpati 8 ☐ ER/Outpati 9 ☐ ER/Outpati 9 ☐ ER/Outpati 1 ☐ ER/Outpati 2 ☐ ER/Outpati 3 ☐ ER/Outpati 3 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Outpati 4 ☐ ER/Out	of 28c. Injury at 2	ne 5 Pesidence 28d. Describe how in		
Divisi	To the Hospital or Atending Physician: The within 24 hours after death.  To the Funeral Director: Atter this certificate h completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, so building, etc. (Specify)	itreet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural ( ate)	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (	29a. Certifier (Check only one)  1 ☐ Certifying Physicien: To the best of my knowledge, deal control on the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause and at the time, date	e(s) and manner as stated and place, and due to the state of the state	ted. he cause(s)
	To t To tl	Ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Da	ay, Year)
7	10		30. Name : d address of person who completed use of lea h (Item 23a) (Type	1 1 1 2 5 6 6 7	m	arch 2	1 2004
	6		Frederic 11, KASS III has 11	110 medical Can	nnis Re	1 Hagen	1 Cooy
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 4 2004  32. Hogistrar's Signature	herle		h	A

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U D L Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** KELLNER ROSE 6:00 A 1, F. APRIL 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 14431 Traville Garden Circle, # 201D Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
FEB 2, 191 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** Days 1□ M 2□F Yrs. MARYLAND 1914 Director 215-09-9822 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r than "natural", or Itams 23a or 28a-f showing Madical Examiner must be notified at 1 X es 2 No MARYLAND MONTGOMERY ROCKVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14431 TRAVILLE GARDENS CIRCLE #201D 20850 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ₩idowed 4 Divorced Specify: þ WHITE permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other traumatic event, the Medical Expons. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SARAH MICHIMOLOVICH HARRIS FRANK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 TIMBER ROCK ROAD, GAITHERSBURG, MD 20878 ERIC S. KELLNER, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEM. GARDENS | 4/4/2004 FALLS CHURCH, VIRGINIA 21. Signature of Funeral Service icensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ISCHEMIC CARDIOMYOPATHY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician P.O. Box 68760 Physiclan/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ynknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No PNEUMONIA autopsy performed? Division of Vital 1 Yes 2 **X**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 🗖 Xo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After or Attanding Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Hospital 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37891 April 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 121 Congressional Lane, # 409, Rockville, Maryland 20852 Amit Rajvanshi, M. D. 31. Date filed (Month, Day Year) APR 0 5 2004 32. Registrar's Signature State south Registrar

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physician
/Medical
Examiner

**Funeral** 

in then "natural", or Items 23e or 28e-f show the Medical Ensuring must be notified at

is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other then "natural", or Ite permit. Pages 1
Department of H
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eny injury or ot

Baltimore, Maryland 21215-0036

Priysician /Medical Examiner

certificate be executed use as the burial-transit led by the attending physician and Division of Vital Records, P.O. Box 68760 or Attending Physicien: this After death. Director: after To the Hospitel

1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month Day 2004 Mary Werres Kirchner April 9:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Carriage Hill of Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Months Days Hours Yrs. Director 1904 Washington, DC 213**-**74-4156 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2½ No Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4625 Saul Road 20895 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify:White 3 Midowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Paul Werres Mary Rohrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire K. Lawless/ Daughter 4625 Saul Road, Kensington, MD 20895 20b. Place of Disposition (Name of 20a. Method of Disposition April 13. 20c. Location - City or Town, State cometery, cromatory or other place)
Gate of Heaven
Cemetery 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee )<u>co</u>la 500 University Blvd. W., Silver Spring, MD 20901 Some 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Cther (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 20No 1 Inpatient 2 EP/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of D ath 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00057124 1300 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao M.D. 13219 Executive Park Terrace, Germantown, MD 20874

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 9 2004

32. Registrar's Signature

		1 - For State Registrar	State of Maryland	-		of Health and of Death	R	leg. No. 20 (	See 5
Physic /Medi	cal	Decedent's Name (First, Middle, Last)     Aa. Facility Name (If not institution, give s	Werner A. Klee	2	4h Ciby Tou	m, or Location of Dea	2. Date of Dea Month April	Day Yea	11:10 P M
Examii Funeral		Suburban Hospital  5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	Bet If Under 1 Y	hesda	8. Date of Birth	Montgon	
Director		117-26-5483  Usual Residence of Decedent  10a. State 10b. County	M 2□F 70	Yrs.		ays Hours Min	Aug. 6,		Germany
YIGITIO K 1 K 13-UU30  ould be filed within 72 hours after death with the Maryland Mentat Hygiene.  arked othar than "natural", or iteme 23a or 28a-1 show attic event, the Mudical Exarting must be notified at	Funerai Director	Maryland Montgome:  10e. Street and Number  4517 Traymore Street	ry E	Sethes	da 10f. Zip Coo	de 20814		Og. Citizen of What	•
ucs after death al', or iteme 23 Everning mus	by		12. Was Decedent Ever in U.S Armed Forces? 1		Was Decedent f Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:			merican Indian,
Maryiand 21215-0036 Id 2 should be filed within 72 hours af the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exer-	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed)  College (1-4or 5+) 5+	(Give life. L	lent's Usual Ockind of work do NOT use re hemist	ecupation one during most of wo stired)		16b. Kind of Busine U.S. Gove	
aryiarid should be file and Mentat Hy marked oths umatic event,	To Be	17. Father's Name (First, Middle, Last)  Charles Klee  19a. Informant's Name/Relationship (Ty)	ne Print)	10h Mailio	a Address /St		me (First, Middle, I		Ti- Code)
The Head		Claude E. Klee/Wife  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Re	e 20b. Pla	4517		e Street,	Bethesda Date		d 20814
parmit. Pages 1 at Department of Heal Important: if item any injury or other once.		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	Mont	RO	Cremator	dress of Facility Pumphrev	Funeral	Home/ C	esda-Chevy
Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death.	Do not ente	er the mode of	onsin Ave. dying, such as cardia			Approximate Interval Between Onset and Death
death certificate be executed  was a steer of the search o	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque  Recurrent  Due to (or as a conseque  Congestive  Due to (or as a conseque	Ventr			ia/Fibril	lation	
b the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnance 1 Live birth 2 Fetal of 4 Pregnant at time of dea	leath 3 🗌	Ectopic pregna Other (specify			23d. Date of o	lelivery Day Year
9 6 6	by	Part II. Other significant conditions conf	tributing to death but not result	ing in the un	derlying cause	given in Part I.			to the cause of death?  Probably 4 🛣 Unknown
The law ate has b	Completed						24a. Was ar autops perform 1 Yes 2	y prior to ned? death'	autopsy findings available completion of cause of es 2 \( \square\) No
pital or Attending Physician: The ours after death.	ertification; To Be	25. Was case referred to medical examiner?  1  Yes 2 No Ho  27. Manner of Death 1 No Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	R/Outpatient 8b. Time of Injury	28c. I	Other: 4 Nursing Finjury at Work?	28d. Describe ho	nce 6 ⊡Other (Sp w injury occurred	
the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filted in by the funer	O	4 Homicide determined  29a. Certifier 1 Certifying Physics	28e. Place of Injury - At hom building, etc. (Specify)  ician: To the best of my knowle	edge, death	occurred at the	e time, date and place	City or Town	. State)	Rural Route Number,
To the Hos within 24 h To the Fun completely	Medical	(Check only 2 Medical Exemin one)  29b. Signature and title of certifier	er: On the basis of examination and manner stated.	n and/or inv	estigation, in n	ense number	irred at the time, da	ate and place, and di	ue to the cause(s)
10		30. Name and address of person who cor			Print)	5818		April 3,	2004
Sta Registi		Sean Dwyer, M.D.  31. Date filed (Month; Day; Year)	32. Registrar's Signatu		spoo	evy Chase,	Marylan	d 20815	

DHMH 17 Rev 1/2001

WERNER, ON/OD/OY 2310

State of Maryland / Department of Health and Mental Hygiene 10 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2004 Year **Physician** April 4, Elizabeth KRAMER 9:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Montgomery Hospice Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 26, 1971 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖳 F 32 Director 203-66-9182 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ret, or items 23a or 28e-f show Exercicer must be notified at 1 ☐ Yes 2 ☐ No <u>Maryl</u>and Montgomery Germantown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 14118 Tattershall Place United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white ð 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 Is marked o Antonio DaSilva Dulce Conciasion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 Wayne Kramer, Husband 14118 Tattershall Place, Germantown, MD other ! 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 № Burial 2 Cremation 3 NRemoval from State injury or 04/07/04 Montefiore Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) Jenkintown, PA 21. Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatice Carcinoma Months /Medical Due to (or as a consequence of) Examiner Castric Cancer
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last 2 Years Examine physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4□Pregnant at time of death 5 Other (specify) the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 🛛 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 2 1 ☐ Yes 2 🔀 No this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 X Natural 1 TYes 2 TNo investigation 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO 9470 April 4, 2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10400 Connecticut Ave., Kensington, MD Eugene P. Libre, M.D., 20895 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State APR 0 5 2004 Registrar

			1 - For State Registrar	State of Mary		artment of F		•	giene Reg. No. 200	4 12782
			1. Decedent's Name (First, Middle, La.	st)				2. Date of De.	ath Day Ye	3. Time of Death
	Physici /Medic		Gopal Aiyer Kri	shna					7, 2004	8:45 A M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Deat	h	4c. County of D	eath
			12109 Hitching Po			Rockvil If Under 1 Year		T = 5	Montgo	
	Funeral		5. Social Security Number 6. S	M 2□F 7. Age (//	n yrs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Birthplace (State or Foreign Country)
	Director		389-44-8202 Usual Residence of Decedent	70				Feb. 5	, 1934   Ir	ıdia
	yland Now		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	e-f sl	ctor	Maryland Montgom	ery	Rockvill	e				1 ☐ Yes 2X No
	ith th	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ath w	rai	12109 Hitching Po			20852			United S	
	er de	nue	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No o Rican, etc.)		merican Indian, /hite, etc.
36	rs aft	by Funeral Director	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specify: A	sian Indian
21215-0036	72 hours after death with the Maryland Insturel', or Items 23a or 28e-f show disal Evantinat her rediffed at	ted	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busine	
215	within 7; ene. then "n	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of word)	rking	National	Institutes
21	giene giene	Completed	20112111217	5+	Pharm	nacologis	t		of Health	
nd	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Last,	)					Maiden Sumame)	
yla	ould Men marke	은	Gopal Krishna Ai	~				i Rangas		
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28e-f show other treumatic event, I'm Medical Evapling minutes rediffied at		19a. Informant's Name/Relationship (						er, City or Town, Stat	
	1 and Health em 27 ther ti		Glenda J. Krishn 20a. Method of Disposition		12109 20b. Place of Dispo	Hitchin  sition (Name of matory or other place			kville, M 20c. Location - City	aryland 20852
nor	ages nt of		1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	cemetery, crei	ium, Inc.	Apr	il 10,	ŕ	
Baltimore,	permit. Pages 'Department of H Importent: If ite any injuger of		' 4 ☐Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer	y)	Cremator:	Lum, Inc. 2. Name and Addre	ss of Facility Ro		Bethesda,	
Ba	Depar Impo any ir		1 Wariel E	Pery. M						Funeral Home/ Avenue,
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	death. Do not ent	er the mode of dyir	ng, such as cardiad	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aSarcon						14 Months
	Examiner			Due to (or as a co	onsequence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	onsequence of):			-		
	d d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	C						
oʻ	e exectant and arrial-tu	EX	resulting in death) Last	Due to (or as a co	onsequence of):					
8760,	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the buriat-transit	dicai		d						
9	that the death certific ed by the attending p detached for use as	/Mec	IF FEMALE:	22a Missa automa of a						
Вох	attenc for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p  1 Live birth 2   4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	′		23d. Date of Month	delivery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	e or death 5					
Ω.	res that igned by be deta	y Ph	Part II. Other significant conditions of	contributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	quires n sign	d by						101	′es 2 <b>X</b> No 3□	Probably 4 Unknown
00	> 10 0	Completed						24a. Was		autopsy findings available
Re	The lav ate has page 2:	от						autop	rmed? death	
Vital	en: tiffica tor, p	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only o		′es 2∭X No
Į /	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Oth	er: 4 🗌 Nursing H	ome 5 X Resid	lence 6 Other (S	pecify)
n of	ng Pt fter th	ü	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. Injur Wor	y at k?	28d. Describe h	ow injury occurred	
Sio	Attending Pirdeath. ector: After to by the funera	catio	2 Accident Investigation 3 Suicide 6 Could not b				Yes 2 □No			
Division	or Att	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm, str Specify)	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	pital ours a erel [		29a. Certifier 1 ☐ Certifying Ph	nysician: To the best of m	u knowledge, deat	h accurred at the time	no data and place	and due to the		
	To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edicai		niner: On the basis of exa and manner stated	amination and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and place, and c	due to the cause(s)
	To the to the comp	Σ	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
	70		1 sound	(8)		D4588	30		April 7,	2004
	0		30. Name and address of person who							
			Leon C. Hwang, M 31. Date filed (Month, Day, Year)	.D. 1396 Pic		ve, Rocky	ville, MD	20850		
	Sta Registi		APR 0 9 20	104 Sener	2	Spork.				

		For State	State	of Mary	•	artment of H		Mental Hyg	200	1. 12792
(A (B) A		Registrar  1. Decedent's Name (First, Middle	e. Last)		Ce.	Tillicate of L	- Jealii	2. Date of Dear	eg. No. CUU	3. Time of Death
Phys				rry	Kubicek			Month April	Day Year 5 2004	
/Me	dical niner				KUDICEK	4b. City, Town, or	Location of Dea		4c. County of De	
		Shady Grove Adv	ventist	Hospita	a1	Rockvi	11e		Montgom	ery
Funer	al	5. Social Security Number	6. Sex	7. Age (Ir	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. B	irthplace (State or Foreign Country)
Directo	or	327-20-5851	1 🔯 M 2 🗆 I		77 Yrs.		110010	May 17,	1926 II:	linois
and	ŭ .	Usual Residence of Decedent  10a. State 10b. County		10	c. City, Town or Lo	ocation				10d. Inside City Limits
Mary -1 • h	ğ	Maryland Mont	gomery		Derwood					1 ☐ Yes 2 🛣 No
r 28a	Director	10e. Street and Number	gomery	J.	Delwood	10f. Zip Code		1	0g. Citizen of What (	Country?
death with the Maryland ims 23a or 28a-f ehow if cual be notified at	0	7627 Quincewood	d Court			20855	5		USA	
r dea	Funeral	11. Marital Status	12. Was D	Decedent Ever d Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (	Specify Yes or No- rto Rican, etc.)	14. Race - An Black, Wh	
s afte	by Fu		ried 1 ☑ Yes,	es 2 No Give	1943-	1 ☐ Yes 2 🖾 No	Specify:	,	Specify:	
hours of tural, or all Extern	d b		Year of	or Dates:	1968	dent's Usual Occupa	1000		W	hite
57 ni	Completed	(Specify only highe	st grade complete		(Give	kind of work done a DO NOT use retired	furing most of wo	orking	16b. Kind of Busines	s/industry
I with	E	Elementary/Secondary (0-12)	Colleg	ge (1-4or 5+)	Secu	rity Offi	cer		Grocery S	Store
d be filed antal Hyg sed other	Be C	17. Father's Name (First, Middle,	Last)					me (First, Middle, M		
Ments Ments	To		ıy	K				Cather	ine Cze	erny
Maryland ZIZIO-UUJO 12 should be filed within 72 hours after death with the Min and Mantal Highere. 11 hand Mantal Highere. 12 handred other than "natural", or liems 23a or 28a-1 fraumetic event, the Microcal Examiner cust be notified.		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street a	and Number or A	lural Route Number	City or Town, State,	Zip Code)
C, R 1 and Health Health ther tr		Margaret Kubice	k/Wife				d Court		, Maryland	
or of History	0	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		om State		natory or other place	' I		20c. Location - City of	
DESILITIONEY, INTERLY ISTICA Z 1 Z 1 3-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mentall Hygiene. Important: If time z7 is marked other than "natural; or liems 23a or 28a-1 ehow any injury or other traumatic event, the Modical Examiner count by notified at		* 4 □ Donation 5 □ Other (S		M						a, Virginia
Depa Depa Impo	once	21. Signature of Furieral Service		all				eVol Fune		VD 00077
		23a. Part1. Enter the disease, or	complications th	at caused the					hersburg,	Approximate
Obvoicio		shock, or heart failure. List Immediate Cause (Final	only one cause of	on each line.	<					Interval Between Onset and Death
Physicia /Medica	_	disease or condition resulting in death)	a. Due	to (or as a co	onsequence of):					HOURS
Examine	er	W	. PN	JEUN	MONIA					IDAY
D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due	to (or as a co	ensequence of):					
and trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	. ,						
o rou, cate be executed bhysicien and the burial-transit	<u></u>	, , , , , , , , , , , , , , , , , , ,	Due	to (or as a co	nsequence of):					
physicate sthe	dical		d							AREHOUSE OF THE STREET
I NECOLUS, F.O. DOX 00/00.  The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of p					23d. Date of de	alivery
death a atte	iclai	in the past 12 months?	4□Pr	ve birth 2 🗆 regnant at time		Ectopic pregnancy Other (specify)			Month	Day Year
by the	hvs	9 Unknown	9L10r	nknown					İ	
ds, r	by P		ons contributing t	o death but no	ot resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
w requires to been signed should be	ted			· · · · · · · · · · · · · · · · · · ·				1 □ Ye	s 2 <b>X</b> No 3□F	Probably 4 Unknown
a law nas b e 2 st	Completed					<del>_</del>		24a. Was ar autops	y prior to	utopsy findings available completion of cause of
VICION: The lav ician: The lav certificate has ector, page 2	ပ်							perform		s 2 No
Ol Vital Physician: rthis certifica	Be	25. Was case referred to medica examiner?	Hospital:	4		• 3D DOA Othe		ath (Check only one		
Phys r this	2	1 Yes 2 No 27. Manner of Death	1	Inpatient ate of Injury Nonth, Day Ye	2 ER/Outpatien 28b. Time of	1 JU DOA	4   Nursing r	Home 5 Reside	nce 6 Other (Spewinium)	ecify)
nding P th. : After	ıtlor	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	'9	Month, Day Ye	ar) Injury	28c. Injury Work M 1 TY	? ′es 2 □ No		.,,,	
or Attending Physician: The after death.  Director: After this certificate he in by the funeral director, page	ifice	3 Suicide 6 Could	200. Pi	lace of Injury -	At home, farm, str	eet, factory, office			eet and Number or F	Rural Route Number,
tel or rs afte	Certification:	113.1110.000		allowing, etc. (5	pocity)			City or Town	, Siate/	
To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifyir (Check only 2 Medicel	g Physician: To Examiner: On th	the best of my	y knowledge, death	occurred at the time	e, date and place	e, and due to the ca	use(s) and manner a ite and place, and du	s stated.
thin 2 the I mplet	Med	29b. Signature and title of certifie	and m	nanner stated.		29c. License			d. Date signed (Mon	
F > F 0		1	1	14			A	. 4		
341		30. Name and address of person	who completed a	ause of death	(Item 23a) (Type	D005		-	IPRIL 05	
		SAFY JOHN	U MD		HADY G	Print) 9901 M	ADVEN	JIIST A	HS FITA	Le, MD. 20850
	State	31. Date filed (Month Day, Xear)		2. Registrar's S	Signature	1	a construction of the second	(1	V-1 ""	
Regis	strar	AI N V O	LOUT	Marie	P	spork	1			

		For State Registrar	State of Mai	yland / Depa <i>Cei</i>	artment of H tificate of I	lealth and M Death	Mental Hygid	ene 2 0 0 a. No.	4 1278!	
Physicia /Medic		Decedent's Name (First, Middle, Last	) Esther		KULAK		2. Date of Death Month April 5.	Day Ye 2004	3. Time of Death 6:45 A	
Examin		4a. Facility Name (If not institution, give Holy Cross Nursing	1.00		· ·	Location of Death		4c. County of E	Death	
Funeral Director		5. Social Security Number 6. Se 147–38–3738		(In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 1)	(ear) 9.	Birthplace (State or Foreigr Country) ew Jersey	
e Maryland	ctor	Usual Residence of Decedent		10c. City, Town or Lo	cation er Spring	2		10d. Inside City Lim 1 ☐ Yes 2 🔯 !		
with th	i Director	10e. Street and Number 14907 Claude Lane	-		10f. Zip Code	20905		g. Citizen of Wha	•	
Irs a	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I □ Yes 2√2 No				American Indian, Vhite, etc.	
within 72 hou iene. Ithan "natura ite Medical E	Completed	15. Decedent's Edd (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+	(Give	tent's Usual Occupa kind of work done of DO NOT use retired	during most of work )	sing	Sb. Kind of Busine		
9 7 5 9 9	To Be C	17. Father's Name (First, Middle, Last) Harry Fleishma				18. Mother's Nam	e (First, Middle, Ma Eisenberg			
es 1 and 2 should be of Health and Ment fittem 27 is marked in other traumatics		19a. Informant's Name/Relationship (T) Sheila Goodfriend,					ral Route Number, ( ver Spr <b>i</b> n		e, <i>Zip Cod</i> e) 20905	
permit. Pages 1 a Department of Hee Importent: if item any injury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,		20b. Place of Dispo cemetery, cren Lakeside	sition (Name of natory or other place	04/0	Date 20	C. Location - City		
Depart Depart Import any inj		21. Signature of Funera Service Licens		To		Hebrew F	uneral Ho			
Physician /Medical		23a. Part1. Error the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Pheum		er the mode of dying	g, such as cardiac	or respiratory arres	, 50	Approximate Interval Between Onset and Death	
icate be executed by physician and common sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Alzhei Due to (or as a	/ >	Sease					
Ine death certii y the attending iched for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	d	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year	
es il	þ	Part II. Other significant conditions co	ntributing to death but	not resulting in the ur	nderlying cause give	en in Part I.		cco use contributi	e to the cause of death?  Probably 4 Munknown	
The law ate as b pag 2 s	e Completed	25. Was case referred to medical						d? prior death	autopsy findings available to completion of cause of ?? es 2 \(\sumbole\) No	
Phys this ral di	ToB	examiner?	dospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day )	28b. Time of	28c. Injury Work	ar: 4 X Nursing Ho	h (Check only one) ome 5 Residence 28d. Describe how		ipecify)	
To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funerel.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc.				City or Town, S	State)	Rural Route Number,	
e Hosp 24 hou e Funei letely fil	edical	29a. Certifier Certifying Phy (Check only one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or inv	occurred at the tim restigation, in my op	e, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner and place, and o	as stated. due to the cause(s)	
Within Toth	Me	29b. Signature and title of certifier  Manual	Irold	nail		number 5346		Date signed (Mo		
/		30. Name and address of person who commercia Goldmark,	M.D., 1190	6 Darnest	,	Suite G	, Darnest	own, MD	20878	
Stat Registra		31. Date filed (Month, Day, Year) 200	4 32. Degistrar	s Signature	Sporks	/				

		1 - For State Registrar	State of Maryland / Dep	artment of Health and ertificate of Death	-	ne 2001	4 1278		
Physi /Med Exam	lical	Decedent's Name (First, Middle, Last     John Edward 1     4a. Facility Name (If not institution, give	Knox	4b. City, Town, or Location of De-	2. Date of Death Month MARCH 2.5	Day Year 5 2004 4c. County of Deat	3. Time of Death		
Funera Directo		212-34-5076	L x 3 M 2□F 7. Age (In yrs. last birthday Yrs.	CUMBERLAND  If Under 1 Year If Under 24 H  Months Days Hours Mi			Y hplace (State or Foreig yland		
e Maryland Be-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Garrett	10c. City, Town or L Grantsv				10d. Inside City Limits		
Daltimore, IMaryland 21213-0035 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or iteme 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	10e. Street and Number  3084 Amish Road  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. 13.	10f. Zip Code 21536  Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	U	Citizen of What Co SA  14. Race - Ame Black, White	ncan Indian,		
Z I Z I 3-UU36 d within 72 hours aff giene er than "naturel, or the Wedfall Fram	pieted by F	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	e completed) (Give	1 ☐ Yes 2 ☒ No Specify:  Ident's Usual Occupation  Ident's Usual Occupation  Ident's Usual Occupation  Ident's Usual Occupation  Ident's Usual Occupation  Ident's Usual Occupation  Ident's Usual Occupation  Ident's Usual Occupation  Ident's Usual Occupation  Ident's Usual Occupation	orking 16b	Specify: Whi			
d be filed with antal Hygiene.	Be	Elementary/Secondary (0·12)  1].  17. Father's Name (First, Middle, Last)  Harvey Knox	College (1-4or 5+) Labore	er 18. Mother's N	ame (First, Middle, Maid Margaret St.	den Sumame)	struction		
e, INIAL YIALIU 1 and 2 should be file 1ealth and Mental Hy 1m 27 is marked oth ther traumatic event	To	19a. Informant's Name/Relationship (Ty Evelyn E. Knox/Wife	3084	ng Address (Street and Number or F	Rural Route Number, Ci ntsville, M	ty or Town, State, 2 D 21536			
Dallimore, Dermit. Pages 1 a Department of Het Importent: If item Iny injury or othe	20a. Method of Disposition  1								
Physiciar /Medica Examine		23a. Part 1. Enter the disease, or comply shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not en	179 Miller Street ter the mode of dying, such as cardia	. Crantsvi	lle, MD	21536 Approximate Interval Between Onset and Death 5 YEARS		
te be executed ysician and be burial-transit	ical Examiner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):						
the death certify y the attending iched for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delive	very Day Year		
w requires that been signed b should be deta	þ		tributing to death but not resulting in the u						
ilcien: The law requir certificate has been si rector, page 2 should &	Be Completed	DIETARY NON COMPLIA  25. Was case referred to medical	ANCE	Of Place of Do	24a. Was an autopsy performed 1 Yes 2 D ath (Check only one)	prior to co	o the cause of death?  robably 4 _Unknown  utopsy findings available completion of cause of  2 _U No		
ing Phys After this uneral di	2	examiner?	ospital: 2 EP/Outpatient 2 EP/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	at 3 DOA Other: 4 Nursing	Home 5 Residence 28d. Describe how in		fy)		
. 2 9 2 2	al Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, Jarm, str building, etc. (Specify) ician: To the best of my knowledge, death	28l. Location (Street City or Town, Sta	nte)				
To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	(Check only one)  2 Nedicel Exemir  29b. Signature and title of cartifier	er: On the basis of examination and/or interest and manner stated.	vestigation, in my opinion, death occ  29c. License number  D19318	urred at the time, date a	(s) and manner as s nd place, and due t Date signed (Month, CH 28 120	o the cause(s)  Day, Year)		
Sí Regis	ate rar	DR.N. RANJITHAN 5 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23a) (Type, 17 OLDTOWN ROAD CUM 32. Registrar's Signature		21502				

-2058	•	Please Type or Print in Black I		-						
3			partment of Health and Me ertificate of Death	ental Hygie Reg.	2001 1070					
Physici		1. Decedent's Name (First, Middle, Last)  Michael J. Lupis		2. Date of Death	Day Year 3. Time of Death					
/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	March 24	4c. County of Death					
		Washington County Hospital	Hagerstown		Washington					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 236-17-7710 12XM 2 F 37 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day Ye 7/15/1966	9. Birthplace (State or Foreign Country) West Virginia					
land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits					
the Mary 28a-f sh	Director	WV BERKELEY 1	MARTINSBURG		1 ☐ Yes 2X No					
3a or	2	254 STUCKEY COURT	10f. Zip Code 25401	10g.	Citizen of What Country?					
death	Funeral		B. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto R	city Yes or No-	14. Race - American Indian,					
il Z i 3-UU30 within 72 hours after death with the Maryland ene. Than "netural", or items 23a or 28a-f show the Medical Evantiene must be incilled at	by	1 X Never Married 2 Married 1 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto R  1 ☐ Yes 2 🕱 No Specify:	lican, etc.)	Black, White, etc.  Specify: White					
72 hg	etec	(Specify only highest grade completed) (Gir	edent's Usual Occupation re kind of work done during most of working	16b	. Kind of Business/Industry					
Mary land Z I Z I 3-UU30 d 2 should be filed within 72 hours att th and Mantal Hyglendal Hyglend 7 is marked other than "natural", or traumatic event, the Madical Exerc	Be Completed	Elementary/Secondary (0·12) College (1-4or 5+)	DO NOT use retired)	(	RLD KITCHEN FACTORY)					
if e, INIAITY IAITO Z IZIO-UUSO s 1 and 2 should be filed within 72 hours after death with the Marylan if Healith and Memtal Hyglene. If the 72 is marked other than "netural", or Items 23a or 28a-1 show other traumatic event, the Medical Examena must be indifficial	To Be	17. Father's Name (First, Middle, Last) Victor C. Lupis, Sr.		zabeth Tre	xler					
s 1 and 2 short set the set of Health and item 27 is m other traum			ling Address (Street and Number or Rural Stuckey Ct., Martinsbur							
Dallimore, Dermit. Pages 1 ar Department of Hea mportant: If item iny injury or other		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition certai	position (Name of Paratory or other place)	te 20c.	Location - City or Town, State					
t. Pag tment tant:		'4 □Donation 5 □Other (Specify) Rosedale		Mar	rtinsburg, W					
Dalltimo permit. Pages Department of Important: If it eny injury or o		Chacles m Brown	327 W. King St., PO Box		Home, nsburg, WV 25402					
Physician	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition									
/Medical Examiner		resulting in death)  Due to (or as a consequence of):	C Myantes							
<b>%</b>	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence or):								
cuted	Examiner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
e be executed risiden and burial-transit		resulting in death) Last Due to (or as a consequence of):								
	dlcal	d								
Bath certificate attending phys	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy								
death e atter	Physician/Medi	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year					
	by Pi	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?					
w require been sig should b				1 🗆 Yes	2 No 3 Probably 4 Unknown					
9 4 6	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?					
ysician: Th	BeC	25. Was case referred to medical examiner?	26. Place of Death (	1 <b>25</b> Yes 2□ N Check only one)	lo 1 Ser 2 No					
hys al di	P.	Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		5 Residence	6 □Other (Specify)					
fe ing	Certification:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  1 Natural 5 Pending (Month, Day Year)	Work?	d. Describe how inj	mestrained diver					
l or Attanding after death. Director: After in by the fune	fica	2STAccident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury: At home, farm, si	700 2000	2 ven	and Number or Rural Route Number,					
spital or Attan ours after deat neral Director: filled in by the	ert	4 ☐ Homicide building, etc. (Specify)		City or Town, Sta	10) S/B 1-810					
To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (	29a. Certifier (Check only one)  1□ Certifying Physician: To the best of my knowledge, dea 2 ☑ Medicel Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and	due to the source/	a) and manner or state d					
To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)					
1		30. Name and address of person who completed cause of death (Item 23a) (Type	O.C.M.E.	<u>M</u>	larch 25, 2004					
24		S.R. HOGAN		Dal+	. Moreville 3.0					
Stat	~ ×	31. Date filed (Month, Day, Year)  32. Registrar's Signature	111 Penn Street,	р <del>ат€щЮ</del> С€	$e_{r}$ maryland $2_{1201}$					
Registra 0HMH 17 Rev 1/200		MAR 29 2004 Breen B. Sp	exter							

ORIGINAL

			1 - For State Registrar	State of Ma		artment of He			ene g. No. 2001	1 12707
I	Physici		1. Decedent's Name (First, Middle, Las Garnetta Louise					2. Date of Death Month March 2	Day Year	3. Time of Death 10:30 a. M
	/Medic Examir		4a. Facility Name (If not institution, give 128 East First S			4b. City, Town, or Lo	own		4c. County of Death Washington	
	Funeral Director		217-32-0924	7. Age	(In yrs. last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 24,	9. Bir 1936 Ma	thplace (State or Foreign ountry) aryland
	Maryland -f show	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Wash:	ington	10c. City, Town or Lo	rstown				10d. Inside City Limits 1 X Yes 2 ☐ No
	h with the 23e or 28a at be noti	al Direc	10e. Street and Number 128 East First S	treet		10f. Zip Code	1740	10	g. Citizen of What C	ountry?
936	within 72 hours aftar death with the Maryland ane. then "naturel", or items 23e or 28a-1 show he Madicel Evaniner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☒ No	anic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify:	
21215-0036	s 1 and 2 should be filad within 72 hours after death with the Marylan if Haalih and Mantal Hyglana. Item 27 is marked other then "naturel", or Items 23e or 28a-1 show other treumatic event, the Madical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 9	ucation de completed) College (1-4or 54	(Give	dent's Usual Occupation kind of work done duri DO NOT use retired) homemaker	on ing most of workir	ng 10	her own	
Maryland	should be filad ind Mantal Hygis marked other umatic event, It	To Be (	17. Father's Name (First, Middle, Last) Milton Moats, Sr		<u> </u>	18	B. Mother's Name Pearl l	(First, Middle, Ma Higgins		
	and 2 shou aalth and N n 27 is mai		19a. Informant's Name/Relationship (7 Leroy C. Lockard			E. First S	Street, 1	Hagersto	wn, Md. 2	1740
Baitimore,	Paga nant c unt: If ury or		20a. Method of Disposition  1基 Burial 2 ☐ Cremation 3 ☐  ' 4 ☐ Donation 5 ☐ Other (Specify	)	Cedar Lav	matory or other place) yn Mem. Park	k 3/29,	/04		n, Maryland
Bai	parmit. Dapartn Imports eny Inju	St. 9	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  MINNICH FUNERAL HOME  415 E.Wilson Blvd., Hagerstown, Md. 21740  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approxim							21740
	Physician /Medical Examiner	Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a	consequence of):	cendom.	etrial	. 1	nomq	Interval Between Onset and Death
8760,	icata ba axacuted physician and s tha burial-transit	dical Exa	resulting in death) Last	Due to (or as a	consequence of):					
P.O. Box 6	The law raquiras that tha death certificata be axacuted ta has bean signed by the attending physician and tage 2 should be deteched for use as the burial-transit	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Petal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
Records, P	w raquiras that bean signed b should ba date	Completed by Pt	Part II. Other significant conditions co	entributing to death but	t not resulting in the u	nderlying cause given i	in Part I.	23e. Did toba 1 ☐ Yes 24a. Was an	2 No 3□Pr	o the cause of death?  obably 4  Unknown  utopsy findings available
Vitai Re		8	25. Was case referred to medical			26	6. Place of Death	autopsy performa 1 Yes 2	prior to death?	completion of cause of
ō	Hng Phys n. Aftar this funaral di	atlon; To B	27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1  Inpatien 28a. Date of Injury (Month, Day	28b. Time of	t 3 DOA Other: 28c. Injury at Work?	4 Nursing Hom	\Z	ce 6 Other (Spe	cify)
Divis	or At ftar d Direct In by	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	building, etc.				City or Town, .		
	To the Hospital or At within 24 hours aftar of To the Funeral Direct complataly filled in by	Medicai	29a. Certifier (Check only one)  2	iner: On the basis of earl manner state	examination and/or inv	r occurred at the time, overstigation, in my opinion 29c. License nu	on, death occurre	d at the time, date	se(s) and manner as and place, and due	to the cause(s)
	F 3 F 8		> this Ha	ompleted cause of de	m, MI	D h	6473		ranch &	16,2004
5	Sta	ite	HIN of HOUM  31. Date filed (Month, Day, Year)	32. Registrar	nD: II	30 OPA	LCT	i Hag	perstour	, MD 21740
	Registr	rar	CA TAIL	UU4 Marce	w 1. p	parte				

			1 - For State Registrar	State of I	Maryland		artment rtificate			ınd M		iene <sub>eg. No.</sub> 2	004	12	788	
	Physici		Decedent's Name (First, Middle, I GENNIE						2. Date of Dea Month APRIL	Day 2,	2004	3. Time of 5: 30	Death am			
	/Medic Examin Funeral Director		GENNIE LEONARD  4a. Facility Name (If not institution, give street and number)  MILLENNIUM HEALTH CENTER				4b. City, Town, or Location of Death FT • WASHINGTON					4c. Cou	Ic. County of Death  PRINCE GEORGE'S			
Į		Director	5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			ast birthday) Yrs.	If Under 1 Year   If Under 24 Hrs.			24 Hrs.	8. Date of Birth (Month, Day) April 3		ear) 9. Birthplac Country)			
e, Maryland 2	he Maryland 8a-f show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  Md. Prince George's Ft. Washington 10g. Citizen of What County?													
	ath with t s 23a or 2 ust be n		12021 Livingston Road						20744				Citizen of What Country? United States			
	I within 72 hours after death with the Maryland liene. Than 'natural' or Items 23e or 28e-f show The Mudical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	If Yes Give			<ol> <li>Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F</li> <li>Yes 2 XNo Specify:</li> </ol>				offy Yes or No- lican, etc.) 14. Race - Ar Black, W. Specify:			merican Indian, hite, etc. Black		
		Completed	(Specify only highest grade completed) (G				edent's Usual Occupation a kind of work done during most of working DO NDT use retired)  COOk				ng	16b. Kind of Business/Industry  Restaurant				
	be filed Ital Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) Sidney Leonard				18. Mother's Name (First, Middle, Patti Gil					Maiden Sumame) .1				
	permit. Pages 1 and 2 should Department of Health and Mer Important: if Item 27 is marke any injury or other traumatic <u>once.</u>		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City  Pearlean Diggs / Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City  3405 Eastern Ave. Mt. Rainer,								r, Md.					
			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  1 ☑ Donation 5 ☐ Other (Spec	r (Specify) Md. Vet				natory or other place) cans Cem. 4-12					Location - City or Town, State Cheltenham, Md.			
Bail			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Capitol Mortuary, Inc.  1425 Maryland Ave., NE Wash., DC 20002													
	death certificate be executed  Example and continued and dor use as the burial-transit  The second death continued and continued		23a. Part 1. Enter the disease, or complications that caused the death. Deglot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List poly one cause on each line.  Approximate Interval Between Onset and Death disease or condition  a.  Concer													
		_	resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.													
ords, P.O. Box 68/60,		al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):													
	ate hy he	/Medical	IF FEMALE:	d23c. If yes, outcon	ne of pregnan											
	t the death or by the atten ached for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	death 3	□Ectopic pregnancy □ Other (specify)					23d. Date of delivery  Month Day Year			oar			
	w requires that the death certific been signed by the attending p should be detached for use as i	۵	Part II. Other significant conditions contributing to death but not resulting in the Cordiac Dysrythmiah Type 2 Diabetes Mellitus					nderlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 🛣 Probably 4 □Unknown				
al Record	n: The law i ficate has b r, page 2 sh	Completed										prior to completion of cause of death?  s 2 □ No 1 □ Yes 2 □ No			/ailable use of	
sion of vital	sicia s certi lirecto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	tiont 2 🗆 E	EP/Outpation	2 DOA	Othor			(Check only one					
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ertification; To	27. Manner of Death  1 Autural 5 Pending 2 Accident investigati					c. Injury Work	TANTONING FIGURE 3 TRESIDE			ow injury occurred				
DIVISION		Certiflo	3 ☐ Suicide 6 ☐ Could not determine	d 28e. Place of I building,	building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		edical	29a. Certifier (Check only one)  1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
		Σ	29b. Signature and title of pertifier				29c. License number D26352					29d. Date signed (Month, Day, Year)  april 6 2004				
_	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print),  OHaya 9[3] / Piscataw ay Ad Winton and													
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 7 200	2. Regis	strar's Signatu	Loss	2									

			of Maryland / Depa	artment of Health and rtificate of Death		ne 2001, 12790
Physic /Mec Exam	lical	1. Decedent's Name (First, Middle, Last)  LANDON JOSEPH LEE  4a. Fecility Name (If not institution, give street and in Maryland Nursing Home)		4b. City, Town, or Location of Deat Clinton If Under 1 Year   If Under 24 Hrs	March 28,	c. County of Death cince Georges
Funera Directo		5. Social Security Number  579-92-2072  Usual Residence of Decedent	1	Months Days Hours Min.	8. Date of Birth September 1997 Year	9. Birthplace (State or Foreign Country) Washington DC
e Maryland 3a-f show	ctor	DC 10a. State 10b. County	10c. City, Town or Lo Washington	1 DC		10d. Inside City Limits 1∭ Yes 2 □ No
ath with the	rai Dire	10e. Street and Number 635 Edgewood ST NE		10f. Zip Code 20017	Uni	Citizen of What Country? Lited States of Americ
1nd 21215-0036  be filed within 72 hours after death with the Maryland nial Hygiene.  nd other than "natural", or items 23a or 28a-f show event, the Medical Exam natural and other than and the confined at	by Funeral Director	Armed  1 Never Married 2 Married 1 Yes,	c 2 57 No	Was Decedent of Hispanic Origin? (Stif Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Black Specify:
nd 21215-0 e filed within 72 ho al Hygiene. I other than "natu	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  8th grade  College	16a. Dece (Give (iife.) (1-4or 5+) Unemp1	dent's Usual Occupation kind of work done during most of wo. DO NOT use retired)	nking 16b.	Kind of Business/Industry
aryland 2 should be filed and Mental Hygi marked other	To Be Co	17. Father's Name (First, Middle, Last) Unknown	chemp		ne (First, Middle, Maide	
Gore, Maryla ges 1 and 2 should tt of Health and Men it item 27 is marke or other traumatic.		19a. Informant's Name/Relationship (Type, Print)  LaurettaI. Temple / gi		ng Address (Street and Number or Ri Edgewood NE WDC		or Town, State, Zip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or eny injury or other traumatic event, the Medical Exam.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro  4 ☐ Donation 5 ☐ Other (Specify)	m State 20b. Place of Dispo cametery, crer Resurrec	sition (Name of natory or other place)	Date 20c.	Location - City or Town, State
Baltim permit. Pa Departmen Important: eny injury		21. Signature of Funeral Service Licensee	Ml 71	6 Kennedy ST NW	WDC 20011	nkins Funeral Home
Fnysiciai /Medica Examine		23a. Pairt: Enter the disease, or complications that shock or heart failure. List only one cause of Immedia Cause (Final disease or condition resulting in death)  Due	at caused the death. Do not end n each line. to (or as a consequent of):	er the mod of dying, such as cardial	or respiratory arrest,	Approximete Interval Between A set and Death
760, te be executed ysician and te burial-transit	Icai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	to (c. as a consequence of):			
D e d hed	Physician/Med	in the past 12 months?	gnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	þ	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death?  2 Lino 3 Probably 4 Unknown
I Rec The law ate has b	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Of Ohys	ion: To Be	27. Many er of Death 1 Natural 5 Pending (M	Inpatient 2 ER/Outpatier te of Injury onth, Day Year) 28b. Time of Injury	ott 3 DOA Other: 4 Nursing F	ath (Check only one) lome 5 ☐ Residence 28d. Describe how inj	
Division of To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: Atter this completely filled in by the funeral of	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pla	ice of Injury - At home, farm, str Ilding, etc. (Specify)	M 1 ☐ Yes 2 ☐ No reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, le)
Hospital     24 hours a     Funeral letely filled	edical C	(Check only 2   Medical Examiner: On the	the best of my knowledge, death basis of examination and/or in anner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause( irred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
To the within To the comple	Me	29b. Signature and uttle of certifier	_	D-24535	29d. D	Pate signed (Month, Day, Year)
/ (U)		30. Name and address of person who completed co		Print) Le C, Room 101, C	linton, MD	20735
S Regis	tate trar	31. Date filed (Month, Day, Year) 32	. Registrar's Signature	ย		

December   Temporary   Company   C				1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H tificate of L			iene <sub>g. No.</sub> 20	004	12790
Redict Examiner  1. Set Sales phene (if one califorms, you make and authors)  1. Set Sales phe	н	Physici	an		•				Month		Year	
HOLY CROSS BOSPTYAL  Story Eventy Many Comments  6. See 1 Comment  6. See 2 See 1 Comment  6. See 2 See 1 Comment  6. See 2 Se						LEE						.:55 P <sup>M</sup>
Second Description   Second		Examin	er									
Design Procession   Total Control   Total Co			-			(In vrs. last hirthday)						
The company of the	l.			466-65-4801					10/27/	1922	Country)	KOREA
Bit   Bit		/land				10c. City, Town or Lo	cation				10d.	Inside City Limits
Bit   Bit		Man a-f sh	ţō	VA FAIRFAX	ζ	GREAT FA	LLS					1 ☐ Yes 2 ☐ No
Bit   Bit		in the	Fed	10e. Street and Number			10f. Zip Code		1	0g. Citizen of \	What Country?	
Bit   Bit		23a d		10501 BIRNHAM I	ROAD		22066			KOREA		
Bit   Bit	9036	ours after des ral', or Items Examble m	þ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 24 N If Yes, Give	0	f Yes, specify Cuba	n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Blac	ck, White, etc.	
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The company of the	121	within nne. ihen	E E		College (1-4or 5-	-)				OUDT I	TOME	
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Physician (Medical Examiner   Medical Examiner	ш	ăo = # a		- MM NU	my our							
February   1   1   1   1   1   1   1   1   1	*	/Medical Examiner	aminer	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	Consequence of):						
The pool of the po	,092	ite be exe iysicien ar ne burial-t	cal Ex	resulting in death) Last	Due to (or as a	consequence of);						
9 Unknown 1 Uyes 2 No 3 Probably 4 Munknown  9	ath certifica	lan/Med	23b. Was decedent pregnant	1 Live birth 2	Fetel death 3						Year	
CONGESTIVE HEART FAILURE  1   Yes 2   No 3   Probably 4   Munknown  24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4   Munknown  25. Was case referred to medical examiner? 1   Yes 2   No 3   Probably 4   Munknown  25. Was case referred to medical examiner? 1   Yes 2   No 3   Probably 4   Munknown  26. Place of Death (Check only one)  27. Wanner of Death 1   Matural 2   ER/Outpatient 3   DOA   28. Date of Injury   Work? 29. Date of Injury   Work? 29. Date of Injury   Work? 29. Date of Injury   Work? 29. Date of Injury   Work? 29. Date of Injury   Work? 29. Date of Injury   Work? 29. Date of Injury   Work? 29. Date of Injury   Work? 29. Date of Injury   Work? 29. Date of Injury   Work? 29. Date of Injury   Work? 29. Date of Injury   Work? 29. Date of Death   Work? 29. Date of Injury   Work? 29. Date of Death   Work? 29. Date of De		the de	ysic			ime or death 5	Other (specify)					
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				31. Date filed (Month, Day, Year)					•			

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			For State Registrar	State o	f Maryland	-	artment <i>rtificate</i>			and Me			200	and the state of t	12791	
	Physici		Decedent's Name (First, Midd     Mee Chiang Lee	le, Last)							2. Date of De Month 4-3-2	Day	у Үөг		3. Time of Death 8:57 P. M	
	/Medic Examin		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, To	own, or	Location o	f Death	7 3 2		County of D	eeth	0.37 1.	
12			Holy Cross Hos	-					Spring				lontgo			
/ ·	Funeral Director		5. Social Security Number 577–80–6197	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. la 88	st birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da 10-14-	y, Year)		Birthptai Country Chin	ce (State or Foreign r) a	
	land wo		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation							100	I. Inside City Limits	
	Mary a-f sh	tor	MD Montgo	omerv	Whea	iton									1 ☐ Yes 2√2 No	
	or 28	Directo	10e. Street and Number				10f. Zip C	ode				10g. Cit	izen of What	Country	17	
	ath w		2701 Arvin St.	1				902				Chi				
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show implies a show implies event, Ita Medical Examinating the notified at	by Funeral	11. Marital Status  t ☐ Never Married 2 ☐ Mar  3 ☑ Widowed 4 ☐ Divorced	ried 1 ☐ Yes	2 xNo ∕e		Was Decede If Yes, specif 1☐ Yes 2		spanic Orig n, Mexican Specify:	jin? (Spec , Puerto R	ify Yes or No ican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Chinese				
Š	2 hou satura ical E	ted	15. Decedent's Education 16a. Decedent's Usual Occupation									16b. K	ind of Busine			
2	ithin 7	Completed	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)								9					
72	lled w dygier ther th		17. Father's Name (First, Middle,	/ acti		Dis	h Wash	er	18 Mother	r's Nama	(Eiret Middle	Food (Restaurant) Maiden Sumame)				
Maryland 21215-0036	d ta b	To Be	Unknown	Ng	V mg				Unkn		riisi, ividule,	Majueri	Sumame)			
Jan	2 shc and is m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											ode)		
Baltimore, I	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic.	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Rou  Kin Yip Lee - Son  20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State										20c. Lo	ocation - City		n, State	
Ħ	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service		Wası	n. Nai	n' L Co	em. Addres	s of Facility	4-9-0	04 es-Rina	Suit	:land,	MD		
ä	Per Per Per Per Per Per Per Per Per Per	y 11	Muan	(h. (	spile	$\sim$ 1	1800 N	lew	Hamos	hire	Ave. S	Silv	er Spr	ing	MD 20904	
18760,	Physician and Medical personned eath ordificate be executed to attending physician and for use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b Ath Due to	onary he (or as a conseque eroscler (or as a conseque ertensio (or as a conseque	atic ence of): ence of):			disea	se					nset and Death	
.O. Box 6	that the death certificated by the attending placed by the attending placed for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1☐Live b	come of pregnand wirth 2  Fetal of leant at time of dea lown	leath 3	Ectopic preg Other (spec						23d. Date of o Month	delivery Da	ay Year	
<u>α</u>	res that t igned by be detar	by Ph	Part II. Other significant condition	_	eath but not result	ting in the u	nderlying cau	ise give	n in Part I.		23e. Did to	bacco u	ise contribute	to the	cause of death?	
ord	w requir been si should	ted	Parkinson's di	sease							1 🗆 Y	'es 2	<b>№</b> No 3 🗆	Probab	ly 4 Unknown	
Il Records,	The la	Completed									24a. Was autop perfor 1 \( \text{Yes} \)	sy med?	prior to	a comp	r findings available letion of cause of ☐ No	
<u>≅</u>	sicien: Th certificate rector, pag	Ве	25. Was case referred to medica examiner?	Hospital:	npatient 2 E		it 3 DOA	Cthe			Check only o					
Division of Vital	ding Pth h. After th funeral	tlon: To	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pendi 2 ☐ Accident invest	'' 4 □ Nur at ? 'es 2 □ N	28	e 5 🗌 Resid			oecify)							
Divisi	- 9	27. Manner of Death  1										itreet and m, State,	d Number or .	Rural R	oute Number,	
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.										ed. e cause(s)				
	To the	Σ	29b. Signature and title of certific	# 1.	-   -				number			29d. Dat	e signed (Mo	nth, Da	y, Year)	
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			30. Name and address of person	•				1.7	heata	n M	2000	2				
l'	Sta	te	Mark K. Li, I	32. R	Universi egistrar's Signatu	ro /				111 611	J ZU9U	<u> </u>				
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day JOSEPH LUCAS. MARCH 31, 2004 7:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GOODWILL MENNONITE HOME GRANTSVILLE GARRETT 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral**  Birthplace (State or Foreign Country) 1**X** M 2□ F Yrs 218-16-4868 82 Director 13, WV AUG 1921 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "netural", or items 23e or 28e-f show treumetic event, the Nedical Examinar must be notified at Director MD 1 ☐ Yes 2 X No GARRETT OAKLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 846 JASPER RILEY ROAD 21550 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricari, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married "netural, or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No δ Specify. Specify: 3 XWidowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DAIRY FARMER FARMING . 1 and 2 should be filed w Health and Mental Hygier Iem 27 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM JOSEPH LUCAS ENELLA YUSCAVAGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I JEANINE BACHTEL - DAUGHTER 846 JASPER ROAD OAKLAND, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 ment of H tent: If ite 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. GARRETT MEMORIAL GARDS. 4/3/04 \* 4 ☐ Donation 5 ☐ Other (Specify) OAKLAND, MARYLAND 21. Signature of Fune 22. Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME -OAKLAND, MD 21550 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Pespiratory
Due to (or as a consequence of): Physician 48 hours /Medical Examiner ementia Sequentially list conditions, if any, leading to lambdiate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) and al-transit or Attending Physicien: The law requires that the death certificate be executed physician ar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? been signe should be cancer, diabete 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 1☐ Yes 25 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 1 Yes 2No Medical Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 virsing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at , Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the f the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospitel 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Da6650 erson who completed cause of death (Item 23a) (Type, Print) Garrett Hwy, Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day **Physician** MARIE ROUSSEAU McDONALD MARCH 29 2004 2:58 A /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BUCKINGHAMS CHOICE NURSING HOME ADAMSTOWN

7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs FREDERICK 8. Date of Birth (Month, Day, AUG 12 Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours 1□M 20 F Months Days 191-32-8502 87 Yrs. **Director** PA Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits or Items 23a or 28e-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No FREDERICK Director ADAMSTOWN 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 3264 GERANIUM COURT 21710 ·USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE Be Completed by 3 Widowed 4 Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Rusiness/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil timent of Health and Mental H tent: If item 27 is marked ott jury or other treumstic even ARTHUR VICTOR ROUSSEAU CLOTILDE JORIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUGENE McDONALD / SPOUSE 3264 GERANIUM CT., ADAMSTOWN, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition FREDERICK CREMAT. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: if any injury or once. 03/29/04 FREDERICK, \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sentice Licenses HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BLEED Physician DIVERTICULAR 4 DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DIVERTICULITI'S DAY ALUTE Sequentially list conditions, if any, leading to in its didtocause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. sate has been signed by the a page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ HY PERTENSION 1 Yes 2 PNo 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 M No 1 ☐ Yes Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 √ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 Tyes within 24 hours after death. To the Funerel Director: A 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

JULIO MENOCIA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MD-1564

MAR 2 9 2004

DHMH 17 Rev 1/2001

32. Projetrar's Signature

29c. License number

OPOSSUMJEWN PILLE

D-31912

CARDENICH

29d. Date signed (Month, Day, Year)

MARCH 29, 2004

				of Maryland / Depart		_	•
			1 - State Registrer		rtificate of Deat		leg. No. 2004 12791
	Physic /Medi	cal		Mckinse		2. Date of Dear Month March	29 2004 7 13 M
	Exami	ner	4a. Facility Name (If not institution, give street and i		4b. City, Town, or Location Hagerstown	n of Death	4c. County of Death
	Funeral Director		Washington County Hosp 5. Social Security Number 212-24-3659  Usual Residence of Decedent	7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day NOV • 28	Washington County  9. Birthplace (State or Foreign County) Maryland
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ta Madical Eraminer must be rectified at	ctor	10a. State 10b. County  Maryland Washington	10c. City, Town or Lo			10d. Inside City Limits  12  12  14  14  14  15  16  17  16  17  17  17  17  17  17  17
	with the or 20	Funeral Director	10e. Street and Number 121 Sunbrook Lane		10f. Zip Code	1	0g. Citizen of What Country?
	death	nera	11. Marital Status 12. Was De	ecedent Ever in U.S. 13.	Was Decedent of Hispanic Cl f Yes, specify Cuban, Mexic	Origin? (Specify Yes or No-	U.S.A.  14. Race - American Indian,
9800	be filed within 72 hours after death with the Marylan Ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Evandrer must be putified at	þ	1 □ Never Married 2 Married 1 □ Yes, 1 □ Yes, 1 Year of	s 2.⊠No Give	If Yes, specify Cuban, Mexic		Black, White, etc.  Specify: White
21215-0036	within 72 h	Completed		(Give (1-4or 5+)	dent's Usual Occupation kind of work done during mo DO NOT use retired) Fulation Clerk	ost of working	16b. Kind of Business/Industry
N	Hygi Hygi ther nt, I	Be Co	12 17. Father's Name (First, Middle, Last)	CIIC		her's Name (First, Middle, M	Newspaper Maiden Sumame)
Maryland	should be and Mental and Mental and Mental and marked o	To E	Bruce Rinehart		Kat	herine Hars	hman
Mar	and and is m		19a. Informant's Name/Relationship (Type, Print) Roland Wolfe McKinsey/				City or Town, State, Zip Code)
	s 1 and 3 if Health item 27 other tra		20a. Method of Disposition	20h Place of Disno	sition (Name of		Maryland 21740 20c. Location - City or Town, State
Ë	Page nent c ant: If ary or		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Smithsbur	g Crematory		Smithsburg, Maryland
Baltimore,	permit, Pag Department Important: I any injury o		21. Signature of Oner II Service Licensee	uley JR 13	Name and Address of Faci 31 Eastern Bl	Douglas A.	Fiery Funeral Home stown, Maryland 21742
	Physician		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or immediate Cause (Final disease or condition	caused the death. Do not ente	er the mode of dying, such a	s cardiac or respiratory arre	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due t	o (or as a consequence of):	/ : 0.	1 - 1 1/1	
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P.O. Box 6	death certif e attending od for use as	by Physician/Med	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
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ora ora	w require been ste should t	ted	Have undery st	itis Um.	mic Obs	Yes	s 2 No 3 Probably 4 Unknown
r	The ate h page	Completed	ung diseuse.	,		24a. Was an autopsy perform	prior to completion of cause of
VII	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes  No  Hospital:	Anpatient 2 ☐ ER/Outpatient	Other	e of Death (Check only one.	Control of the Contro
TO HOL	After	atlon: T	27. Manner of eath 28a. Date		28c. Injury at Work?  M 1 Yes 2	ursing Home 5 ☐ Residen 28d. Describe how No	
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	No the Hospital or within 24 hours after To the Funeral Dirticompletely filled in I	edical	29a. Certifier (Check only one)  1 Sertifying Physician: To the 2 Medical Examiner: On the and many many many many many many many many	e best of my knowledge, death basis of examination and/or invenier stated.	occurred at the time, date ar estigation, in my opinion, dea	nd place, and due to the cau ath occurred at the time, date	use(s) and manner as stated. e and place, and due to the cause(s)
	vithin To the comple	Mec	29b. Signature and title of certifier	mor stated.	29c License number	200	d Data signed (Marth Co., V.
	,		May & Money	6).	02381	S	1arch 29, 2009
K	۲,5		30. Name and address of person who completed cau	ise of death (Item 23a) (Type, F	Print) 1/1 51/-	est Nac	March 29, 2004 115 Hown MD 217,
	Sta	te	31. Date filed (Mon Apr YSar) 2004 32.	egistrar's Signature	vulle alle	er Mage	1540an MIDXI1
	Registr	_	2004	seem S. Sp	ules		

Registrar

O. Box 68760

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State

31. Date filed (Month, Day, Year)

APR 0 9 2004

32, Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State Registrar				ertificati	e of l	Death		Reg. N	<u>6.20</u>	Uls	121
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Funeral Director		5. Social Security Number 577–13–4775	1.X M 2□ F	1. Age (III	yrs. last birthda Yrs.	Months			in. 8. Date of l (Month, 1	Birth Day, Year	1985	9. Birthpia Count	ace (State or i ry) ington
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Department of health and Mental rivglene. Important: If item 27 is marked other than "natural, or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Bo Commissed by Europea Disorder.	]	10a. State 10b. County		100	c. City, Town or	Location						10	d. Inside City
a-fa	5	Maryland Prin	ce Georg	es	Lan	ham							1 X Yes 2
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Physician //Medical Examiner  Willis Leroy Mangum  4a. Facility Name (If not institution, give street and number) 9010 Briarcroft Lane  Laurel  S. Social Security Number 213-16-2447  Usual Residence of Decedent 10a. State  10b. County  10c. City, Town or Location  Ab. City, Town, or Location of Death  Laurel  Prince George's  Funder 1 Year   If Under 1 Year   If Under 1 Year   If Under 24 Hrs.   Months Days   Hours   Min.   Month April 1, 2004  6:00 a  4c. County of Death  Prince George's  9. Birthplace (State or Fore Country)  Feb. 15, 1916   Washington, I			For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Marylar		artment of rtificate of			Reg. No. 201	3. Time of Death
Social Security Number   Color   100 colors   100 color	/Medic	al .	Willis Leroy Mang	um		4b. City, Town	or Location of Dea	Month April	Day Yea 1, 2004	6:00 a M
Sa. Sales   100. County   100. Event of Dynamic   100. Event of Event of Dynamic   100. Event of Event of Event of Event of Dynamic   100. Event of			5. Social Security Number 6. Se 1213-16-2447	7. Age (In yrs.		If Under 1 Yea	r If Under 24 Hr	. (Month, Des	h 9. B	irthplace (State or Foreign
Willis L.Mangum, Jr Son P.O. Box 543, Clear Spring, Maryland 21722  20a Memor of Disposition City of Town. State   Date   Committee of Committee	r 28a-1 show	Irector	10a. State 10b. County  Maryland Prince G						10g. Citizen of What (	10d. Inside City Limits 1 X Yes 2 Nc
Willis L.Mangum, Jr Son P.O. Box 543, Clear Spring, Maryland 21722  20a Memor of Disposition City of Town. State   Date   Committee of Committee	urs after death witi al', or Items 23a o	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Amed Forces? 1 X Yes 2 No 19 If Yes, Give	942-	Was Decedent of If Yes, specify Cu	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - An Black, Wh	nite, etc.
Willis L.Mangum, Jr Son P.O. Box 543, Clear Spring, Maryland 21722  20a Memor of Disposition City of Town. State   Date   Committee of Committee	ed within 72 hou ygiene. ser then "naturs t, itte Medical E		(Specify only highest grad	cation e co <i>mpleted)</i>	16a. Dece (Give life.	kind of work don DO NOT use retii	e during most of w red)		Painters Washington	Union
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introval blank-wash shock, or heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of heart fature. List only one cause on each of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks. List only one cause of death?  23a. Date of delivery and the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of the submitted blanks and shock of	permit. Pages 1 and 2 should be file Department of Health and Mental Hy mportant: If item 27 is marked oth nny injury or other traumatic event. 2008.	Be	John William Mang	rpe, Print)			Ida S et and Number or F	mith Rural Route Numbe	r, City or Town, State	
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Sequentially list conditions.  Familier  The first of the	permit. Departrimporte any injt		1 March	FM/	4	739 Balt	imore Av	e., Hyatt	sville, M	20781
Testing in death   Last   Color   Co	/Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line. <sub>a.</sub> Cardiomyopa	thy					Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hypertension    1   Yes   2   No   3   Probably   4   Unknown	ate be hysicia he bur	ca	that initiated events	Due to (or as a consec						
Hypertension    1   Yes   2½ No   3   Probably   4   Unknow	0 0 0	ysiclan/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 Live birth 2 Feta 4 Pregnant at time of c	al death 3		су			•
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28. Date of Injury  28.	es ti igne be d	þ								
27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury - At home, farm, street, factory, office  28b. Time of Injury at Work? 1   Yes 2   No  28c. Injury at Work? 1   Yes 2   No  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred  28d.	in: The law r dificate has be or, page 2 sh								sy prior to med? death? 2 ☑ No 1 ☐ Ye	completion of cause of
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	nding Physicie ath. r: After this cert e funeral direct	2	examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	I Inpatient 2	28b. Time o	f 28c. Inj	ther: 4 Nursing ury at ork?	Home 5∑ Resid	ence 6 Other (Sp	ecify)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	pital or Atteurs after des arat Directo		4 Homicide determined	building, etc. (Special	fy) 			City or Tow	n, State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To the Hosp within 24 ho To the Func completely f	Medica	(Check only one)  2 Medicel Exemi	ner: On the basis of examina	ation and/or in	vestigation, in my 29c. Licer	opinion, death occ	curred at the time, d	late and place, and du 29d. Date signed (Mor	ne to the cause(s)
· · · · · · · · · · · · · · · · · · ·	(5) 1Va		30. Name and address of person who co			Print)				7

Deceder's Name (First, Middle, Last)   State of Death (Noted Polath (N			1 - For State Registrar	State of Maryland / De	epartment of Health and No	Mental Hygie	•				
4. Fully Name of their Name of the Arrivation Country of Death Prince Corry of Death Read of Death Prince Corry of Death Prince Corry of Death Prince Corry of Death Prince Corry of Death Prince Corry of Death Prince Corry of Death Prince Corry of Death Prince Corry of Death Prince Corry of Death Prince Corry of Death Prince Corry of Death Read of Death Prince		an al	1. Decedent's Name (First, Middle, Last)  Robert All			2. Date of Death Month	Day Year 7.004				
\$ 5.0000 Security Number   6.0 set   100 months   100 mon		er <sup>4</sup>				h	4c. County of Death				
10.5 State of 10.5 County   10.5 County		5 2	5. Social Security Number 6. Sex 227-42-3862	7. Age (In yrs. last birtho		8. Date of Birth (Month, Day, Y) March 17	(ear) 9. Birthplace (State or Foreign Country) Roanoke, VA.				
Time   Towns   Time   Towns   Time   Towns   Time   Towns   Time   Towns   Time   Towns   Time   Towns   Time   Time   Towns   Time	38-f show	_ 1	10a.State 10b.County Maryland Prince Geo		ashington		10d. Inside City Limits 1 ☑ Yes 2 ☐ No				
198 Informant's Name Plastinication (Pype, Prett)   199 Mailing Address (Siree and Alember or Rural Floure Name)	3a or 2f	A Dire		oad							
198   Informant's Name-Flatinisticity (Type, Print)   198   Mailing Address (Siree and Mamber or Rural Pouts Mamber, City or Town, State, 20 Code)	f, or items 2	þ	11. Marital Status 12. 1 □ Never Married 2⊠ Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.				
190 Mailing Address (Street and Authore or Rural Pouts Authore, City or Town, State, 20 Code)   190 Jennie Mason/Spouse   1804 Hollydale Rd. Fort Washington, 190 Oate   20c. Lecation. City or Town, State, 20 Code)   1804 Hollydale Rd. Fort Washington, 190 Oate   20c. Lecation. City or Town, State   20c.	an "natural Medical E		15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)	ation completed) 16a. De (G	Give kind of work done during most of work life. DO NOT use retired)	rking	6b. Kind of Business/Industry				
19b. Maling Address (Street and Number or Runal Roste Number, City or Town, State, 2p Code)   19b. Maling Address (Street and Number or Runal Roste Number, City or Town, State, 2p Code)   19b. Maling Address (Street and Number or Runal Roste Number, City or Town, State, 2p Code)   19b. Maling Address (Street and Number or Runal Roste Number, City or Town, State, 2p Code)   19b. Maling Address (Street and Number or Runal Roste Number, City or Town, State, 2p Code)   19b. Maling Address of Part State, 2p Code)   19b. Maling Address of Part State, 2p Code)   19b. Maling Address of Part State, 2p Code)   19b. Maling Address of Part State, 2p Code)   19b. Maling Address of Part State, 2p Code)   19b. Maling Address of Part State, 2p Code)   19b. Maling Address of Part State, 2p Code)   19b. Maling Address of Part State, 2p Code)   19b. Maling Address of Part State, 2p Code)   19b. Maling Address of Part State, 2p Code)   2a Maling Address of Part State, 2p Code)   2a Maling Address of Part State, 2p Code)   2a Maling Address of Part State, 2p Code)   2a Maling Address of Part State, 2p Code)   2a Maling Address of Part State, 2p Code Part State, 2p Co	ed other that a swent, the	Be 1	12 17. Father's Name (First, Middle, Last)	ne (First, Middle, Mai	uiden Sumame)						
A   Donation   S   Other (Specify)   AFILINGTON Nat' 1 Cem. April 20, 200 AFILINGTON, VA.	s marks sumatic										
A   Donation   S   Other (Specify)   AFILINGTON Nat' 1 Cem. April 20, 200 AFILINGTON, VA.	fitem 27 ly or other tre	-	20a. Method of Disposition	20b. Place of Di cemetery,	Disposition (Name of crematory or other place)	Date 200	c. Location - City or Town, State				
23a. Part. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  ### Approximate of conditions contributing to death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  #### Approximate of conditions contributing to death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  #### Approximate of conditions contributing to death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  #### Approximate of conditions contributing to death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  #### Approximate of conditions contributing to death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  #### Approximate of conditions contributing to death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  #### Approximate of conditions contributing to death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  #### Approximate of conditions contributing to death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  #### Approximate of conditions contributing to death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  #### Approximate of conditions contributing to death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  #### Approximate of conditions contributing to death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  #### Approximate of conditions contributing to death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  ##### Approximate of conditions contributing to death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  ##### Approximate of conditions contributing to death. Do not enter the mode of dying.  ##### Approximate or dying the proximate of death. Do not enter the mode of dying.  ##### Approximate or dying the proximate or death. Do not enter the mode of dying.  ##### App	mportent: If eny injury o		* 4 □Donation 5 □ Other (Specify)	Arlingt	con Nat'1 Cem. April	ope Funera	I Homes				
The signature of the state of t	ysician and burial-transit le burial-transit le burial-transit le cal Examiner	Sequentially list conditions farmediate cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
The s 2 No 3 Probably 4 Unknown and seasof performed to medical examiner?  24a. Was an autopsy performed?  1 yes 2 No  25. Was case referred to medical examiner?  1 yes 2 No  26. Place of Death (Check only one)  27. Manner of leath in Natural	ched for use as	ysicianume	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death							
24. Was allopsy performed?   25. Was case referred to medical examiner?   1   Yes 2   No   No   No   No   No   No   No	P 8	ر ک	Part II. Other significant conditions contril	buting to death but not resulting in th	e underlying cause given in Part I.	. ^					
Second   S	page 2			autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No						
27. Manner of feath 1 Natural 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 7 Manuel 2 Sec. Injury at Work? M 1 Yes 2 No 2 Sec. Injury at Work? Morth	s =   .Ο	0	examiner?	spital: 1   Inpatient   2   ER/Outp	Other		e 6 □Other (Specify)				
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number Range Vision 29d. Date signed (Month, Day, Year)  30. Name and a ress of terson who completed cause of denth (Item 23a) (Type, Print)  30. Name and a ress of terson who completed cause of denth (Item 23a) (Type, Print)	5 7 7		Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injur	ne of 28c. Injury at work?  M 1 Yes 2 No	28d. Describe how in					
30. Name and a ress of verson who completed cause of denth (Item 23a) (Type, Print)  Bolling Firmly Proceedings 28 Brotling Ave BAFB 20032 447-553	illed in by f		4 Homicide determined	building, etc. (Specify)		City or Town, St	State)				
30. Name and a ress of verson who completed cause of denth (Item 23a) (Type, Print)  Bolling Firmly Proceedings 28 Brotling Ave BAFB 20032 447-553	pletely fi		(Check only Z   Medical Examiner:	rred at the time, date a	a(s) and manner as stated. and place, and due to the cause(s)						
Bolling Frankly Procheellene 28 Brothly Ave BAFB 20032 - 467-553	To th	<b>E</b> 2	Walter of the same	les no	MD OFFICE	sylvanized.	Date signed (Month, Day, Year)				
	10/		Polling Familia	Practice Clark	200, Print) 238 Brothly A	WE BAF	B 30032 467-553				

			1- For State of Maryland /		artment of H		•	giene Reg. No. 20	01 10==
24	Physici		Decedent's Name (First, Middle, Last)     Ruby Anne McGee				2. Date of De Month April		3. Time of Death 9
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Adventist Health Care Sligo Cree  5. Social Security Number 6. Sex 7. Age (In yrs. last		Takom If Under 1 Year	Location of Death  a Park  If Under 24 Hrs.  Hours Min.	8. Date of Bir (Month, Da	4c. County of De	omery  inthplace (State or Foreign
	Director		578-62-1034 1□ M 2√2 F 95  Usual Residence of Decedent  10a. State 10b. County 10c. City, To	Yrs.	Months Days	Hours Min.	August	3, 1908 T	ennessee
	the Maryla 28a-f ehov	ector			Spring  10f. Zip Code			10g. Citizen of What	1⊠Yes 2 □ No
	sath with	Funeral Director	1316 Penwick Lane Apartment #612		20	910	ait. Vaa aa Na	USA	,
920	ours after de ral', or Item Examerar	by	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:			spanic Origin? (Spe n, Mexican, Puerto I Specify:	Rican, etc.)		nerican Indian, nite, etc. Black
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-1 ehow event, ite Medical Examinar must be motified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1·4or 5+) 5+	(Give life. [	lent's Usual Occupa kind of work done o DO NOT use retired Cial Work	turing most of workii )	ng	16b. Kind of Busines D.C. Gove	
yland ;	D d la b	To Be C	17. Father's Name (First, Middle, Last) John H. Knox			18. Mother's Name Estell	(First, Middle, e Leona		
Mar	s 1 and 2 should f Health and Mer flem 27 is merke other traumatic					Ave., Ad		er, City or Town, State 1D 20783	, Zip Code)
Baltimore,	Page ment o ant: If ury or		20a. Method of Disposition 20b. Place ceme	e of Dispos etery, crem	sition (Name of natory or other place	atory 4/7	ate	20c. Location - City of Brentwood	
Balt	permit. Departr Imports eny inji		21. Signature of Funeral Service Licensee  Mugglin T. Wolet M01322	3		ro ensburg R	d, Bren	oln Funera	
8760,	Physician /Medical Examiner physician and physician and the pruial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cardiac Arrh Due to (or as a consequence Hypertension Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence Cause (Disease or injury that initiated events resulting in death) Last	hythm ce of): tic H	iia		Tespiratory at	1931,	Approximate Interval Between Onset and Death
O. Box 6	The law requires that the death certific tie has been signed by the attending p lage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting Dementia	g in the un	iderlying cause give	in in Part I.		obacco use contribute (es 2 No 3 F	to the cause of death? Probably 4 ★JUnknown
Vital Records,		Completed	Failure to thrive				24a. Was autop perfor 1 \( \text{Yes} \)	rmed? prior to	
Ö	ng Phy fter this meral d	tion: To Be	27. Manner of Death 28a. Date of Injury 28b 1⊠Natural 5 ☐ Pending (Month, Day Year)	/Outpatient b. Time of Injury	28c. Injury Work	4 ( Wind sind Hou	ne 5□ Resid	ne)  Jence 6 Other (Sp  Jow injury occurred	ecity)
Division	D # T E	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, stre			8f. Location (S City or Tow	Street and Number or F m, State)	Rural Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled to make the best of my knowled and manner stated.	dge, death and/or inv	estigation, in my op	inion, death occurre	d at the time, o	date and place, and du	e to the cause(s)
	To To To	2	29b. Signature and title of certifier		29c. License	6/47		29d. Date signed (Mor	nth, Day, Year)
-	(10)		30. Name and address of person who completed cause of death (Item 23a Nasreen Kango, M.D. 7610 Carroll		•	205, Tako	oma Par	k, MD 2091	2
TR.	Sta Registr		31. Date filed (Month, Day, Year)  APR 0 6 2004  P. Registrar's Signature		K				

			For State Registrar	State of M	larylan		artment rtificate			and M		gien Reg. N	200	Ļ	128	00
	Physici	an	Decedent's Name (First, Middle, I		26						2. Date of De Month	D	ay Yes		3. Time of D	
ji.	/Medic Examin		4a. Fecility Name (If not institution, g	Mary Dean		uso	4b. City,	Town, or	Location of	of Death	April		c. County of D	eath	7:05	_A <sup>M</sup> _
1			9213 Vendome Dri						hesda				Montgo			
	Funeral Director		5. Social Security Number 6 282-26-3299 Usual Residence of Decedent	. Sex 7. A 1 □ M 2 ☑ F	80	last birthday) Yrs.	If Under Months	1 Year Days	If Under	Min.	8. Date of Bir (Month, De Nov. 1.	th 19, Year 3 , 1	923	Birthplace Country Cana	ce (Stete or I ') ida	Foreign
	yland now		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d	. Inside City	Limits
	e Mar	ctor	Maryland Montg	omery		Bet	hesda								1 Yes 2	2 <u>17</u> No
	with the or 2	Funeral Director	10e. Street and Number 9213 Vendome Dr.	ive			10f. Zip		0817				itizen of What			
	death	nera	11. Marital Status	12. Was Deceden	t Ever in U	.S. 13.	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)	United States No- 14. Race - American Indian,			Indian,	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Iteme 23s or 28s-1 show aumatic event, It a Medical Evanthar must be notified at	þ	1 Never Married 2 Married 3 ™ Widowed 4 Divorced		No		1 ☐ Yes 2			, rueno i	nican, etc.)		Black, W	Whit		
Maryland 21215-0036	thin 72 h	Completed	15. Decedent's (Specify only highest (Secondary (0-12)		r 5+)		kind of wor DO NOT us	l Occupa k done d e retired,	ition furing most )	t of workir	ng	:	Kind of Busine		stry	
2	ited wi Hygien ther th		12 17. Father's Name (First, Middle, La	ist)		Homei	maker		18 Mothe	r's Name	(First, Middle,	1	o Sumama)	e		
_	- 0 5	To Be	Donald McDonald	31,7							Hedaler		,, Samano,			
Mary	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic e once.	-	19a. Informant's Name/Relationship				_		ind Numbe	r or Rura		er, City	or Town, State	208		
Baltimore,	of Hear		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	□Removal from State	20b. F	Place of Dispo			.1	D	ate		Location - City	or Towr	n, Stete	
T I	trant: Pag		*4 □ Donation 5 □ Other (Spe	cify)	Mon	tgomery			n f	2004	٠,	Bet	hesda,	Mar	yland	
Ba	Depar Impor any ir		21. Signature of Funeral Service Unit	ensee	МО	0198 Ro	bert 57 Wis	A. F Scons	umphi sin Av	rey E	uneral ethesd	Hon	Beth me/ Cha D 20814	ase 1-35	a-Chev Inc.	уу
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	omplications that cause by one cause on each	ed the deat	h. Do not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory a	rrest,		În	pproximate nterval Betweenset and De	een
0	Physician /Medical Examiner		disease or condition resulting in death)	a. Seven		ronic (	bstru	ıcti	ve Lu	ng D	<u>isease</u>			Ye	ars	
	uted d ansit	Examiner	Sequentially list conditions, many, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (c. a	s a conseq	juence of).										
,097	ite be executed sysician and he burial-transit	cal	resulting in death) Last	Due to (or a	s a conseq	uence of);										
.O. Box 68	The law requires that the death certifica Nie has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	ıl death 3 □	Ectopic pre						23d. Date of o Month	delivery Da	ay Yea	ar
rds, P.	quires that n signed b uld be deta	by	Part II. Dther significent conditions Chronic Atrial I					_					use contribute			
Division of Vital Records,	sician: The law requir certificate has been si rrector, page 2 should	Completed	History of Poli	0							24a. Was autop perfo 1 Yes	sy med?	prior t death	o comp	findings av	ailable ise of
Ita		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		0 10,	03 21		
of <	Jing Physician:  Atter this certification funeral director.	2	1 ☑ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpa		ER/Outpatien			4   Nu				6 Other (S)	pecify)		
O	ding Atte	tlon	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, D	ay Year)	Injury	M	Bc. Injury Work 1 □ Y	odi ? ′es 2∐1		8d. Describe h	iow inje	ary occurred			
Divisi	after death after death Director: d in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	ad 200. Flace of I	njury - At he etc. (Specif	ome, farm, str	eet, factory	, office		2	8f. Location (\$ City or Tox		nd Number or te)	Rural R	loute Numbe	97,
	To the Hospital or Att within 24 hours after d To the Funeral Direct gampletely filled in by	edical C		Physician: To the best manner: On the basis and manner s	of examina											
	To the To the	N.	29b. Signature and title of certified	4	117			License				29d. Da	ate signed (Mo	nth, De	y, Year)	
Ī	105		, 01/		NU	/		000	5949	7		4	1404			
_			Mary E. Callsen,	•				. #3	00, F	Rockv	ille, I	Mary	yland 2	0852	2	
H	Sta Registr		31. Date filed (Month, Day, Year)  APR 0 7 2	2004 32. Regis	trar's Signa	sture &	Spo	uks	,							

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 April 2 Physician Marinucci 3:30 P Cristino /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) 6. 1925 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1<del>√</del>2 M 2 □ F 577-40-4805 Italy 78 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or itame 23a or 28a-f show event, the Medical Examinating the continual 1 XYes 2 No Directo Maryland Bethesda Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with 8607 Split Oak Circle 20817 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelih and Mental Hygiene. I important: If Item 27 is marked other than "natural; or Itan any injury go other traumatic event, the Medical Expiral intuition. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 utility contractor construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Venanzio Marinucci Maria Domenica Ventresca 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Guiseppina Marinucci - wife 8607 Split Oak Circle, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. Apr. 6, 2004 Silver Spring, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of FacilityHines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring,MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Cerebral Infarction /Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4☐ Pregnant at time of death 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 X No the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after useum.
To the Funeral Director: / investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 101 no, mo 20057124 413104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, 13219 Executive Park Terrace, Germantown, MD 20874 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 5 2004 Registrar APR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yeer Physician 2004 Edward G. Maxey, Sr. April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Takoma Park
If Under 1 Year | If Under 24 Hrs. Washington Adventist Hospital
Social Security Number 6. Sex 7. Age (In yrs. last birthday) Montgomery

9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1⊠M 2□F Months Director 89 1915 Virginia Jan. 579-10-<u>3</u>024 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28e-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Silver Spring the 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Itame 23e USA 9115 Flower Avenue 20901 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "netting of other traumatic any injury of other traumatic any injury of other traumatic and injur 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Meat Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ John Duigiud Maxey Sally Amelia Whipple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward G. Maxey, Jr. Son 4780 W. Princeton Avenue Denver Colorado 80236 20b. Place of Disposition (Name of cametery, crematory or other place)
National Memorial
Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Apr. 7, 2004 Falls Church Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901 21. Signature of Funeral Ser ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Finat disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner near rowari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a og sequence of) Examiner The law requires that the death certificate be executed **burial-transit** and Due to (or as a consequence of): ed by the attending physicien detached for use as the hurring P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 🗍 Unknown has been signed by 3e 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No or Attanding Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) After 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗀 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 21900 10 and address of person who completed cause of death (Item 23a) (Type, Print) AMINA S FO 7610

31. Date filed (Month, Day, Year)

APR 0 6 2004

Registrar DHMH 17 Rev 1/2001

State

Carroll 32. Registrar's Signature

			T ICUS	State of Maryland	d / Department of Health an	d Mental Hygiene	)
		-	For State Registrar		Certificate of Death	Reg. No	2004 12803
	Physici	_	Decedent's Name (First, Middle, L	James	5 McNeil	2. Date of Death Month Da	Yeer 13. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g		4b. City, Town, or Location of D	ealh 4c.	County of Death
*			THE JOHN 1	40pKins HUS	pital Baltinure	, CIXY	NA
	Funeral		0. 000-2. 000-2,	Sex 7. Age (In yrs. la 1⊠M 2□F 3	ast birthday) If Under 1 Year If Under 24  Months Days Hours M	Hrs. 8. Date of Birth (Month, Day, Year) April 12, 2	9. Birthplece (State or Foreign Country) Maryland
	Director		217-57-3940 Usuel Residence of Decedent			April 12, 2	
	ryland		10a. State 10b. County	10c. City	y, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	8a-f s	Director	Maryland Howar	d El	llicott City 10f. Zip Code	10c Cit	tizen of What Country?
	with the	Dir	10e. Street and Number 4721 Middle Cou	rt	21043	log. Cit	USA
	ms 23	Funerai	11. Marital Status	12. Was Oecedent Ever in U.		? (Specify Yes or No-	14. Race - American Indian,
Maryland 21215-0036	be filed within 72 hours after death with the Maryland and bylginen.  d other than "natural", or itams 23a or 28a-f show a other than "natural Examinar must be notified at event, the Medical Examinar must be notified at	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, P  1 □ Yes 2 型 No Specify:	uerto Hican, etc.)	Black, White, etc.  Specify: White
2-0	72 ho 'natur	Completed	15. Decedent's (Specify only highest		16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 16b. K	ind of Business/Industry
121	within ene then	idui	Elementary/Secondary (0-12) None	College (1-4or 5+)	Never Worked		N/A
d 2	filed Hygie other	Be Co	17. Father's Name (First, Middle, La	st)		Name (First, Middle, Maiden	217 22
la l		To B	Michael A.	McNeil	Sara	h P. DeMarco	
lary	s 1 and 2 should Health and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street and Number of		
	and tealth im 27		Michael A. McNe		4721 Middle Court,		ocation - City or Town, State
Baltimore,	@ O = 5		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3	☐Removal from State	emetery, crematory or other place)	April 3.	
Itim	artment ortant: injury o		<ul><li>4 □ Donation 5 □ Other (Spe</li><li>21. Signature of Funeral Service Lice</li></ul>		apolis Memorial Gardens 22 Name and Address of Facility Francis J. Collin	the state of the s	napolis , Maryland
Ba	Dep Impo	V S	1 William	I Brux	500 University B1	vd. W., Silve	er Spring, MD 20901
R	571		23a. Part1. Enter the disease, or construction shock, or heart failure. List or Immediate Cause (Final	omplications that caused the death	h. Do not enter the mode of dying, such as car	diac or respiratory arrest,	Approximate Interval Between Onset and Death
檀	Physician /Medical		disease or condition resulting in death)	a. Tun to the as a consequence	uence of: 1	5	acrimute)
Ark.	Examiner			, pulmona	in hemory	Mar	20 minute
	7 4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (or as a consequ	uence of:	01.11.0	A Julany
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Watt Ve	VSW) MUST ABEUK	of the 1411	IWEEK
760,	be ex ician burial	cai E		Vone. W	MINDOU TOURS	lant.	9 month
687	ficate g phys			d		321	- tringer
Вох	The law requires that the death certificate ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. if yes, outcome of pregna 1 □ Live birth 2 □ Fetal	ancy If death 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
	at the deal by the att tached for	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown			Month Day Feat
P.0	that the			s contributing to death but not res	ulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,	uires that signed ld be de	d by	X-linked	2. Utoimmu	nity alleraic	1 □ Yes 2	3 Probably 4 Unknown
COL	w require s been si should i	Completed	dusponille	1600 SIINO	amo	24a. Was an	24b. Were autopsy findings available
Re	sician: The law s certificate has t lirector, page 2 s	шо	- Or oping of the	are y sqra	The state of the s	autopsy performed? 10 Yes 2 □ No	prior to completion of cause of death?
<u>ta</u>	ctor, p	Be C	25. Was case referred to medical examiner?			Death (Check only one)	
of V	hysic this ce al dire	မ	1 □ Yes 2 0 10			ng Home 5 Residence 28d. Describe how inju	
no On	ding F h. After funer	tion	27. Manner of Death  1 Shatural 5 ☐ Pending 2 Checident investiga		28b. Time of Injury at Work?  M 1 □ Yes 2 □ No		ny occurred
Division	Atten r deat octor:	Certification:	3 Suicide 6 Could no	ot be 28e. Place of Injury - At ho	ome, farm, street, factory, office		nd Number or Rural Route Number,
Ö	s after	Cent	4  Homicide	building, etc. (Specify	y) 	City of Town, State	ө)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical			owledge, death occurred at the time, date and pation and/or investigation, in my opinion, death		
	other of the comple	Mec	29b. Signature and title of certifier	1 (1:0	29c. License number	29d. Da	ate signed (Month, Day, Year)
)	. 21-0		18 Ishledo	CerMO	RE-0	00 Ma	MM28 2004
			30 Name and address of person w	no completed cause of death (Item	J. WOLESTOR + V	baltimor.	4. MD 21287
ì	St	ate	31. Date filed (Month, Day, Year)	32 Pegistrar's Signa	ature & Spark	1-1	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mildred McRant April 2004 12:50pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Nursing&Rehabilitation Clinton r 1 Year | If Under 24 Hrs. Prince George's 5. Social Security Number 7. Age (In yrs, last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1□ M 2□F 579 40 2881 Director 74 02/20/30 North Carolina Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Mudical Executaer count be notified at DC NONE Washington 1 □Xes 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 3808 Hayes Street NE#1 23a USA Funeral 20019 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? or iteme 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Affiled Folces?

1 ☐ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: Specify: Black 3 ☐ Widowed 4 ♥ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 strough and Department of Health and Mental Hygiene Importent: if item 27 is marked other the any injury or other traumatic event, the once. Government Nursing Assistant 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur W. Mathews Essie Jones ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Williams 2969 Brinkley Rd#102 Temple Hill, Md20748 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 4/9/04 Suitland, Md <sup>22, Name and Address of Facility</sup>
Snead Funeral Home& Cremation Service
5732 Georgia Ave NW Washington, DC 20011 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Scleratic Cardio Vascular disena Immediate Cause (Final **Physician** hero disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): -burialthe attending physician Box 68760, Physician/Medical as the IF FEMALE: use 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I ☐Yes 2 ☐ No 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 200 1 ☐ Yes 2 ☐ No 3 Probably 4 DUnknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. I Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0022708 1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Meers mn SouThern AVESE #307 ZONOZI 132 8 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 06 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2004 **Physician** APRIL 2, BEATRICE MENDELSON FRIEDMAN 10:30 A.M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 F AUG 29, 1923 Director 229-16-2207 80 PENNSYLVANIA Usual Residence of Decedent 10a. State 10b. County r 28a-f show 10c. City, Town or Location 10d. Inside City Limits 1 ☐¥es 2 ☐ No VIRGINIA NONE **ALEXANDRIA** Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rai', or itama 23a or Examiner must be 3412 ALABAMA AVENUE 22305 UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Examina 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: 3 ₩Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 ADMINISTRATIVE ASSISTANT HOSPITAL Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ARNOWITZ **JACOB** FRIEDMAN ٩ MTRTAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARILYN M. DAVIS, DAUGHTER 3412 ALABAMA AVENUE, ALEXANDRIA, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) KING DAVID MEMORIAL GDN. 4/4/2004 FALLS CHURCH, VA 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility once. DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. south. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Films) RCINOMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of): Physiclan/Medlcai the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 2 No Month 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown been signed t should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 Probably 4 □Unknown 1 Yes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has funeral director, page 2 certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours at To the Funaral D completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 1 29b. Signature and titly of ertific 29d. Date signed (Month, Day, Year) 29c. License number 2 20 30. Name and address of person who completed cause of death (Item 23a) - pe, Print) MONTROSE RD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 5 2004 Registrar

			For State Registrar		State of	Marylan	•	artment rtificate				ental Hy	giene	0001	128	306	
	Physici	an	1. Decedent's Name (First, Midd	ile, Last	)							2. Date of De Month	aath Da	y Year	3. Time of	Death	
	/Medic	al	Betty M. 4a. Facility Name (If not instituti.		iller	200)		4b. City, To		I costion o		April		2004 County of Dee	1:45	a M	
1	Examin	ıer	,							sburg			46.	•			
	Funeral		Wilson Healthc 5. Social Security Number	6. Se	x 7.	y VIII. . Age <i>(In yr</i> s.		If Under 1	Year	II Under		8. Date of Bi (Month, D	rth	Montgo 9. Bji	thplace (State of	or Foreign	
	Director		578-09-1723	1[	□M 2ØF	93	Yrs.	Months [	Days	Hours	Min.	July 29	0, 19	10 Mai	cyland		
	and w		Usual Residence of Decedent  10a. State 10b. Count	·v		10c. Cit	y, Town or Lo	ocation							10d. Inside C	ity Limits	
	Maryl f sho	ğ	Florida Bro	ward	1		Dearfi	eld Be	ach						1 ☐ Yes	2 🖾 No	
	r 28a	Director	10e. Street and Number	ware	•		Deciri	10f. Zip C					10g. Cit	izen of What C	ountry?		
	th wit	a D	390 North Fed	eraJ	Highwa	Highway, #405 33441								USA			
	tems rems	Funeral	11. Marital Status	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								0-	14. Race - American Indian, Black, White, etc.				
36	rs afte	by F	1 ☐ Never Married 2 ☐ Ma 3 🖾 Widowed 4 ☐ Divorce		1 ☐ Yes 2 If Yes, Give Year or Dat			1 ☐ Yes 215	No No	Specify:				Specify: Wh:	lte .		
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or items 23e or 28e-f show event. I'm Medical Eraphiser must be notified at	ted	15. Decede	ent's Edu	ucation		16a. Dece	dent's Usual (	Occupa	tion		16b. Kind of Business/Industry					
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and	ould be fil Mental H arked ott atic even	Be	17. Father's Name (First, Middle John Halas	. ,								(First, Middle Belagyi		Sumame)			
Maryland	s should be filed within and Mental Hygiene. Is marked other than aumatic event, I.e.M.	2			ype, Print)		19b. Maili	ng Address (S	Street a					or Town, State,	Zip Code)FL	33///1	
	and 2 27 fs		Severine G. Le	Powe off]	r of At er, Jr.	torney	390								rfield		
ore,			20a. Method of Disposition		Ramoval from St	1 ~	Place of Dispo	osition (Name matory or othe	of		D D	ate	20c. Lo	ocation - City or	Town, State		
Ë	Pages ment of I ant: If it	١,	'4 □Donation 5 ☑Other				ort Li	ncoln C	Cemer	tery	Apr. 20	i1 8,	Bre	ntwood,	Maryla	nd	
Baltimore,	permit Depart Import any in	Severine G.  20a. Method of Disposition  1 Burial 2 Cre  '4 Donation 5 \$\frac{1}{2}\$  21. Signature of Funeral		6	alex)		5 5	Pane and rancis OO Univ	J. vers	Coll Sity	ins F Blvd	uneral W.,S	Home:	e Inc. r Sprin	g, MD 2	0901	
п			23a. Part1 Enter the disease, shock, or heart failure. Li	or comp st only c	lications that cau	sed the deat on line.	h. Do not en	ter the mode o	of dying	, such as	cardiac or	respiratory a	ırrest,		Approximat Interval Bet Onset and	ween	
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Box (	leath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outco			75						23d. Date of de	livery		
œ.	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No			th 2 Feta nt at time of d		Ectopic preg Other (spec						Month	Day '	Year	
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Rec	The lav	Completed								· · · · · -		auto perf	psy ormed?	prior to death?	completion of c		
Vital		0	25. Was case referred to medic	ai						26. Place	of Death	1 ☐ Yes		1 Yes	2 No		
Ϋ́	\$	To B	examiner? 1 ☐ Yes 2 🛣 No		Hospital: 1 ☐ Inj	patient 2	ER/Outpatier	nt 3 DOA	Othe	r: 4 🛣 Nu	rsing Hon	ne 5 🗀 Res	dence	6 □Other (Spe	icify)		
n of	ding Ph n. After th funeral	on:	27. Manner of Death 1   Natural 5 □ Pend	ding	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury		. Injury Work			8d. Describe	how inju	y occurred			
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	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		29a. Certifier (Check only one)  29a. Certifier (Check only one)  1												i)		
	To the Within To the	Me	29b. Signature and title of certif	ier 🔿	A	n	1	29c. L	icense	number			29d. Da	te signed (Mon	th, Day, Year)		
	3		ple	K	Mul	wick	e mi		D192	294			Apr	16,	2004		
	フ		30. Name and address of person					Print)							/		
			John R. R. 31. Date lilled (Month, Day, Yea	ar)	ick M.D	. 911	Russe				ther	sbu <b>r</b> g,	MD	20879			
	Sta Regist	ate rar	APR 0	7 20	04	gistrar's Signa	19	spa	rks								

		1 - For State Registrar	State of M	Marylan	d / Depa <i>Cei</i>	artmen tificat	t of H e of L	ealth a Death	and M		Reg. No	/ 11 (1	4 12	808
Phýsici /Medi	cal	Decedent's Name (First, Middle, Last     JOHN  4a. Facility Name (If not institution, give)	JOSEPH	c)	MOOD		Town or	Location o	f Death	2. Date of De Month MARCH	25, Da	2004	8:30	of Death O P M
Examir Funeral	ner	3112 Valley View  5. Social Security Number 6. Se	Court		last birthday)	If Under	Gap1	and If Under 2	24 Hrs.	8. Date of Bir	th	Washin		or Foreign
Director		Usual Residence of Decedent	[] M 2	75	Yrs.	Months	Days	Hours	Min.	(Month, Da 4-22-1	928 928		Colorado	0
the Marylar 28a-f show	Director	Maryland Washingt	on		y, Town or Lo	10f. Zip	Code				10a Ci	tizen of What		City Limits  2 X No
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28e-f show aumatic event, the Maryland Exported to a troffled at	by Funeral	3112 Valley View  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Court  12. Was Deceder Amed Forces 1  Yes 27 If Yes, Give Year or Dates	s? ]No			21 dent of Hi city Cubar	779 spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	Un	ited S 14. Race - Al Black, W	tates	Th.
1 within 72 haliene.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		r 5+)	life. I	kind of woi DO NOT us	rk done d	uring most	of worki	ing		al est	,	
& da b	To Be C	Norman Moody  18. Mother's Name (First, Middle, Last)  Norman Moody  Hannorah Coleman										Sumame)		
1 and 2 sho Health and Hem 27 is m		Norman Moody  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2  3112 Valley View Crt., Gapland, MD 21779										9		
Pages lent of nt: If it		20a. Method of Disposition  1 Burial 2 Sermation 3 1  4 Donation 5 Other (Specify,  21. Signal of Juneral Service Licens	)	a	derick	Crem	ator	y M	arch	29,04 North	Fre	derick	, Maryla	and
permit. Departr importa any inju	0	our treel	Math	ed the death	br	unswi	.ck,	MD	Stau	ıffer F	uner			te
Physician /Medical Examiner white private per executed the private transit tra	231. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												Onset and I	
The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pro						23d. Date of c		Year
w requires that been signed b should be deta	b	Part II. Other significant conditions co	4	but not resu	ulting in the ur	nderlying ca	ause give	n in Part I.			obacco u Yes 2	. 0	to the cause of d	
The law recate has be page 2 sho	Completed	V					24a. Was autor perfo 1 Yes	osy rmed?	prior to death	autopsy findings and completion of care	available ause of			
or Attanding Physician: The law requires talter death.  Director: Attent this certificate has been signe in by the funeral director, page 2 should be of	ation: To Be	examiner? 1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Special Content of the Content of									pecify)			
pital or Attaurs after de ors after de oral Directo	i Certification:												ber,	
To the Hospital or Atlanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	tion and/or inv	ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29c. License number  29d. Date signed (Month, Day, Year)  March 26, 2004  a) (Type, Print)  mas J6 hram brive Frederick, M0 21702										
10		30. Name and address of person who c	ompleted cause of	death (Item B 72c	23a) (Type,	John	rom	priv.	e	Freder	ick	, MO	21702	
Sta Registi		31. Date filed (Month, Day, Year)	32. Regis	kar's Signa	ture	Angel	81							

Amend Item #5 per filates of 1/25/1940 das Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dey **Physician** March 29, 2004 9:45 A.M. Lela Virginia Maust /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Grantsville Garrett 520 Crab Run Road If Under 1 Year If Under 24 Hrs.

Wonths Deys Hours Min. 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 52Social Security Number **Funeral** Months 1 □ M 2 🂢 F Yrs. March 16,1926 Pennsylvania Director 78 Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Exactiner must be notified at 1 ☐ Yes 2√ No Director <u>Grantsville</u> MD Garrett 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 520 Crab Run Road 21536 IISA Funeral Peges 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itema 23, ury or other traumatic event, the Medical Exactinar natal 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Yoder Lewis C. Bender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul A. Maust/Husband 520 Crab Run Road, Grantsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of important: if it any injury or conce. Nation | Burial | 2 □ Cremation | 3 □ Removal from State Dry Run Cemetery, April 1, 2004 4 ☐ Donation 5 ☐ Other (Specify) Bittinger, MD 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Servica Licansee 2l2 179 Miller St, POBox 275, Grantsville, MD 21536 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finat disease or condition resulting in death) /Medical one month Examiner Due to (or as a consequence of): Physician/Medical Examiner ettending physician end I for use es the buriel-transit Attending Physician: The law requires thet the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Tes 2 No sete hes been signed by page 2 should be detect 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? astima 1L Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Hospitel: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) s efter death.
ai Director: After th funeral 27. Manner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 TYes 2 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide ō To the Hospital within 24 hours e To the Funeral C completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Yeer) 29c. License number D35481 March 30, 2004 loude 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 3 Mark Sagin, M.D., Memorial Hospital, 600 Memorial Ave., Cumberland, MD 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signature State Registrar 2004

			For State Registrar	State o	f Maryla	-	artment of F			Reg. No. 200	4 12810
	Physicia /Medic	al	Decedent's Name (First, Middle     Donald     Aa. Facility Name (If not institution)	Linds		McG	regor 4b. City, Town, o	r Location of De	2. Date of De Month	Day Year  2 9 0	4 8-10 AM
	Examine Funeral	er	Atlantic Gener  5. Social Security Number	al Hospita 6.Sex	a1	s. last birthday,	Berli	n If Under 24 F		Worces	ster inthplace (State or Foreign Country)
	Director		579-34-8559 Usuel Residence of Decedent  10a. State 10b. County	13∑M 2□F		74 Yrs.		Tiodis III	Dec. 15	, 1929 Was	hington, D.C.
	death with the Maryland ims 23a or 28a-f show	ector	Delaware Suss	ex		Selbyvi				10g. Citizen of What C	1 ☐ Yes 2X∑No
	3a or 2		10e. Street and Number 68 East Stone	y Run			19975	i .		USA	ountry :
36	be filed within 72 hours after death with the Marylan ital Hygiene.  et other than "natural", or Items 23a or 28a-1 show event, the Medical Examination is ust by multiled at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	ied 1 XYes	2 🗆 No	u.s. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		(Specify Yes or No Jerto Rican, etc.)	Black, Wh	nerican Indian, lite, etc. Vhite
Maryland 21215-0036	vithin 72 hounde.	Completed by	Elementary/Secondary (0-12)	t's Education st grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired teamfitte	during most of ( d)	working	16b. Kind of Busines	
land 21	2 should be filed within and Mental Hygiene. Is marked other than " raumatic event, the Me	To Be Co	11 17. Father's Name (First, Middle, Herman		cGrego		Ceamire			, Maiden Sumame) Walker	
	and 2 shou alth and M 27 is mar er traumal		19a. Informant's Name/Relations Lois S. McGrego			68 Ea	st Stoney		Selbyvill	e, Delaware	e 19975
Baltimore,	permit. Pages I and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (5	pecify)	State	cemetery, cre	osition (Name of matory or other place Veterans		Date / 1 / 0 4	20c. Location - City of Millsboro,	
Balt	permit. Departr Imports any inj		21. Sign vury of Funeral Service	JAWA 1		H		uneral		lbyville, I	
11929 2004 760,	Physician and burial-transit sthe burial-transit	Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	cords a cons	hage- equence of):	•	ng, such as care		irrest,	Approximate Interval Between Onset and Death
(B) 13/15/ (D) 3/25/ (O) Box 687	ne death certif the attending thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 □Fi nant at time o	etal death 3	□Ectopic pregnanc	у		23d. Date of d Month	elivery Day Year
S, P	quires that the signed by ald be detacted	þ	Part II. Other significant conditi	ons contributing to c	eath but not i	resulting in the	underlying cause giv	ven in Part I.		tobacco use contribute Yes 2 No 3 1	to the cause of death? Probably 4 □Unknown
REGOR FSS9	The law requir cate has been si page 2 should I	Completed							24a. Was auto perfi 1 🗆 Yes	s an 24b. Were a prior to death?	autopsy findings available completion of cause of completion of cause of ca
Mc G 34 - 8 of Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hoepital		Περιο	-1 2/7 POA OU	-	Death (Check only	one) idence 6 □Other (Sp	ang if d
- 113 0	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, I	ation: To	1 Yes 2 No  27 Manns of Death  1 Autural 5 Pendi 2 Accident invest	28a. Date	Inpatient 2 of Injury oth, Day Yeer,	28b. Time Injury	of 28c. Injui			how injury occurred	recity)
Donald 579-	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 289. Plac	e of Injury - A ling, etc. (Spe	t home, farm, s ecify)	treet, factory, office		28f. Location City or To	(Street and Number or i wn, State)	Rural Route Number,
	the Hospit in 24 hour the Funera poletely fills	edicai	(Check only 2 Medica one)	Examiner: On the I	e best of my loasis of exam oner stated.	knowledge, dea unation and/or i	nvestigation, in my	opinion, death o	ace, and due to the	cause(s) and manner , date and place, and di	ue to the cause(s)
	ANA ANA	Σ	29b. Signature and title of certific	UL.	1	shep se	29c. Licens	4428	7	29d. Date signed (Mod	4
10 D	X		30. Name and address of person	who completed cau	ise of death (I	1733 (Type	telthing	Drue	Bers	le, ms	
	Sta Registi		31. Date filed (Month, Day, Year MAR 3	1 2004 32.	Registrar's Si	gnature	Apour	EV .		•	

PO

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mile and the		Decedent's Name (First, Middle, I	Last)		2. Date of Dea		3. Time of Death
Physici /Medi		MORTBA N.	McDONALD			1, 2004 Year	1000 a
Examir		4a. Fecility Name (If not institution, g		4b. City, Town, or Location of De	eath	4c. County of De	ath
		14200 Hampshire	e Hall Ct.	Upper Marlbor		Prince	Georges
uneral irector		069-72-8982	. Sex 1 ★ M 2 □ F 7. Age (In yrs. last birthda Yrs.		8. Date of Birt (Month, Da)		rthplace (State or Fore country) York, City
Mo II		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Lim
28a-f eh	ector	Maryland Prince	George's Upper M				Yes 2
23a or 3	al Dir	14200 Hampshire	Court	10f. Zip Code 20772		10g. Citizen of What C	ountry?
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Enumer rulal ba notified at once.	by Funeral Director	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Tes 2 ▼No If Yes, Give Year or Dates:	B. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu  1 ☐ Yes 2 ☐ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify: B	ite, etc.
"natura	leted	15. Decedent's (Specify only highest of	Education 16a. Dec (Giv.	cedent's Usual Occupation ve kind of work done during most of v . DO NOT use retired)	working	16b. Kind of Business	s/Industry
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even	Be	17. Father's Name (First, Middle, La	•	18. Mother's N	lame (First, Middle,	Maiden Sumame)	
narked o	ပ္	George DeLanio			<u>e Elizabe</u>		
7 le m traum		19a. Informant's Name/Relationship George McDonald/		iling Address (Street and Number or			
item 27	W A	20a. Method of Disposition	20b. Place of Disp	Marlboro Pike #3	O3 Forest	VILLE, Md.  20c. Location - City of	
t: If it y or o		1 ☐ Burial 2 ☐ Cremation 3	Removal from State cemetery, cri	ematory or other place)		ŕ	
Important: any injury c		'4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lig	ensee	ashington 4/9 22. Name and Address of Facility	0/04 Frazier's	Paramus, N Funeral H	ome Inc
mpo any i							
	11 1	PN, AD	Laren	389 R.I. Ave., N.	W. Wash.	,DC 20001	
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After this certificate has been signed by the attending physician and mineral director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause there Underlying Cause (Lisease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Aprilications that caused the death. Do not envious use on each line.  a. Complications of Sar Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3  4 Pregnant at time of death 5  9 Unknown  contributing to death but not resulting in the least of liniury (Month, Day Year)  1 28a. Date of Injury - At home, farm, see 28e. Place of Injury - At home, farm, see 28e. Place of Injury - At home, farm, see 28e. Place of Injury - At home, farm, see 28e. Place of Injury - At home, farm, see 28e. Place of Injury - At home, farm, see 28e. Place of Injury - At home, farm, see 28e. Place of Injury - At home, farm, see 28e. Place of Injury - At home, farm, see 28e. Place of Injury - At home, farm, see 28e. Place of Injury - At home, farm, see 28e. Place of Injury - At home, farm, see 28e. Place of Injury - At home, farm, see 28e.	Dectopic pregnancy Other (specify)  underlying cause given in Part I.  26. Place of D  26. Place of D  27. Injury at Work? M 1 Yes 2 No  treet, factory, office	23e. Did to 1	23d. Date of de Month  bacco use contribute to es 2 \( \text{No} \) 3 \( \text{P} \) Pin 24b. Were all prior to death? 2 \( \text{No} \) No 24b. Were all prior to death? 2 \( \text{No} \) No 24b. Were all prior to death? 2 \( \text{No} \) No 25b. Solution (Special Prior to Annual Prior to Prior to Annual Prior to Prior to Annual Prior to Prior to Annual Prior to Prior to Annual Prior to Prior to Annual Prior to Prior to Annual Prior to Prior to Annual Prior to Prior to Annual Prior to Prior to Annual Prior to Prior to Annual Prior to Prior to Annual Prior to Prior to Annual Prior to Prior to Annual Prior to Prior to Annual Prior to Pr	livery Day Team Onset and Death  livery Day Team Onset and Death  Onset and Death

State Registrar

31. Date filed (Month, Day, Year)

APR 1 6 2004

			For State Registrar	State of M	arylan		artmen <i>rtificat</i>				lental		ene 20	104	128	312
ı	Physici	an	1. Decedent's Name (First, Middle, Last,								2. Date of		Day	Year	3. Time of	
	/Medic Examir		Antonina Lillia  4a. Facility Name (If not institution, give				4b. Citv.	Town, or	Location of		April	. 6,	2004 4c. County	of Death	6:15	ам
	Lxaiiii	lei	Shady Grove Ad			a1		ckvi					·	gomen	v	
	Funeral		Social Security Number     6. Security Number	7. Ag		ast birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date o	f Birth			lace (State o	r Foreign
1	Director		Usual Residence of Decedent	M 261F	93	Yrs.					Dec.	11,	1910	Nev	Yor	K
	yland Iow		10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside Ci	ty Limits
	a-fsh	ctor	Maryland Montgome	ry	Sil	ver Sp	ring								1 🗆 Yes	2 🔀 No
	ith the	Directo	10e. Street and Number				10f. Zip	Code				109	g. Citizen of	What Cour	itry?	
	death with the Maryland rins 23e or 28a-f show		3500 Fitzhugh Lan					906					USA			
136	id be filed within 72 hours after death with the Marylan lental Hygiens. Ked other than "natural", or Items 23e or 28e-1 show the other than "natural", or lense to out the modified at ite event, the Medical Evaluation into the colified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☼ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	•		Was Deced If Yes, spec 1 ☐ Yes 2	rfy Cuba	spanic Origin, Mexican Specify:	gin? (Spo i, Puerto	ecity Yes o Rican, etc.	r No- )	Bla	ce - Americ ck, White, V: Whit	etc.	
3-003b	72 ho	Completed	15. Decedent's Edu (Specify only highest grad			16a. Dece	dent's Usua kind of wor	Occupa	ation	t of works	00	16	6b. Kind of B	usiness/Ind	dustry	
Z	ithin 19.	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	lite.	DO NOT us	e retired	)	OF WORK	ng					
7	filed w Hygier ther ti		17. Father's Name (First, Middle, Last)	4		Hor	nemake	er	19 Motho	de Name	(Circt Mi	tello 14	Ow niden Suman	n Hon	ie	
yiand	d be f ental l ked of	To Be	Joseph Bruno								a Pol		lideri Suman	10)		
ary	2 should be and Mental Is marked of aumatic ev	-	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Address	(Street a					City or Town,	State, Zip	Code)	
, mar	and 2		Matthew J. Nevins	Jr./ So		6012	Willo	w H:	i11 L	ane,	Derw	ood	MD 2	0855		
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic and once.		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ P	emoval from State	Ce	ace of Dispo	sition (Nam	e of her place	-) [		ate	20	c. Location -		wn, State	
	tment tant: riant:		*4 ☐ Donation 5 ☐ Other (Specify)		Gat	e of Ceme	tery				10 <sub>.</sub>	S	ilver	Sprin	ng, MD	
g	Depar Depar Important any ir		21. Signature of Funeral Service Licens	handa		Fr	. Name and	J.	Co113	ins :	Funer	al E	lome I	nc.		
7			23a. Part 1. Enter the disease, or compli	cations that caused	the death	. Do not ent	O Uni	vers	sity l	B <b>Ivd</b> cardiac c	r respirato	S1] rv arres	ver S	pring	Approximate	9
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ie cause on each li	ne.										Onset and C	veen Jeath
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	EM (  Jence of):  FIR	,,,,					•				
	Examine:	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	A S	PIR	ATI	DN	P	NE	UM	DA	IA			
	uted 1 Insit	Examiner	Cause (Disease or injury	D40 10 (01 43	a consequ	once or,										
Ď	exect en and rial-tra		that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):										
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õ ×	entifica ding pl	Med	IF FEMALE:	On Maria automa	26 - 42											
POX	atter for u	ician/Me	in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pre						23d. Dat Mor	e of delive	*	ear
	the d by the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown		a o_	other jape					_				
λ T	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions con	tributing to death b	ut not resu	lting in the ur	nderlying ca	use give	n in Part I.		23e. C	id tobac	cco use contr	ribute to th	e cause of de	ath?
	equire sen si										1	Yes	2 <b>2</b> No	3 Proba	ıbiy 4 ⊡U	nknown
ပ္သ	12 SS SB	Completed										utopsy	P	prior to con	sy findings a	vailable use of
<u> </u>	sician: The lav certificate has rector, page 2										1□ Ye	erforme s 2/		leath?	2 <b>5</b> 2No	
N I G	sicial s certifirecto	o Be	25. Was case referred to medical examiner?  1  Yes 2 Ao	ospital:	2	R/Outpatien	3 DO		26. Place							
õ	g Phy ler this neral c	-	27. Manner of Death	28a. Date of Inju		28b. Time of		c. Injury Work	at				e 6 Othe			
	endin sath. or: Afi he fur	atio	1 Accident 5 Pending investigation	(Month), Da)	y reary	Injury	М		es 2□N	10						
Ž N	To the Hospital or Attending Physicien: The I within 24 Hours after death, within 24 Hours after death, To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At hor c. <i>(Specify)</i>	me, farm, stre	et, factory,	office		2	8f. Locatio City or	n (Stree Town, S	et and Numbe State)	er or Rural	Route Numb	er,
	P Hospi 24 hou Funer etely fill	edicai	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	ician: To the best of er: On the basis of and manner sta	examinati	vledge, death on and/or inv	occurred a estigation,	t the time in my op	e, date and inion, death	d place, a	nd due to i	he caus ne, date	e(s) and ma and place, a	nner as sta and due to	ited. the cause(s)	
	To the Within To the	Me	29b. Signature and title of certifier	521			29c.	License	number			29d.	Date signed	Month, E	ay, Year)	
	12		Inne	Buc	)/	me	)	20	05	7/.	24		4/6	100	1	
			30. Name and address of person who co				Print)									
			Truong Bao M.D.  31. Date filed (Month, Day, Year)	13219 Exe			k Ter	race	, Ger	mant	own,	MD	20874			
	Sta Registr	100	APR 0 7 200	32. Registra	a s Signati	4	Soo	ako.	/							

State of Maryland / Department of Health and Mental Hygieney Certificate of Death

	- negistrar			00,	imouto or i	Journ	H
	1. Decedent's Name (First, Midd	le, Last)					2. Date of Deat
Physician /Medical	Rose Marie	Nazit					April
Examiner	4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, or	Location of Death	
	Peninsula Regio	NOI Medi	ral	Center	5	9/15/11/4	
uneral	5. Social Security Number	6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth

Director

the Maryland

200-28-9975

OSE NAZIT

item 27 is markad othar than "natural", or items 23a or 28a-f shov othar traumatic evant, the Medical Examinar must be notified at should be filed within 7 and Mental Hygiene. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic avent

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

burial-transit Division of Vital Records, P.O. Box 68760. as the t After

To the Hospital or Attanding after death. within 24 hours a To tha Funaral I mp

Day ZUDH 4c. County of Death HICOMICO 9. Birthplace (State or Foreign Months Days Hours 1□M 2☑F 91 Yrs. 200-28-9975 05/25/1912 Illinois Usuel Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1√2 Yes 2 ☐ No Director DE Sussex Dagsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 Dogwood Estate Drive 19939 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Zentack Anna Yazabek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann J. Reinohl / Daughter 41 Dogwood Estate Drive, Dagsboro, DE 19939 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State `4 □ Donation 5 □ Other (Specify) Eastern Shore Crematorium | 04/02/04 Lewes, DE 21. Signature of Funeral Service Licensee MO0866 22. Name and Address of Facility Parsell Funeral Homes & Crematorium Tan 1449 Kings Highway, Lewes, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVD Due to (or as a consequence of): HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PNEUMONIA ASPIRATION Due to (or as a consequence of): DEMENTIA Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2. No 2□ No 1 Yes 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 😿 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 2 Accident 6 Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/2104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 504B , Salisbury, Das MD 106 Milford ST. # APR 0 6 31. Date filed (Monti 32. Registrar's Signature State

Registrar

		•	For State Registrar	State o	f Marylan	d / Depa <i>Cei</i>	artment of H	lealth a Death	and Men	tal Hygier		12814
-	\$		1. Decedent's Name (First, Midd	le, Last)						Date of Death	Day Year	3. Time of Death
	Physici: /Medic		BETTY	A. ONL	ΕY				i i	arch 2		7:20 a M
1	Examin		4a. Facility Name (If not institution	n, give street and nu	m <i>ber</i> )		4b. City, Town, or	r Location of	f Death	250,=24	4c. County of Dea	
			Malcolm Grove	Hospital			Suitl				Prince G	
	Funeral Director		5. Social Security Number 579–64–1216	6. Sex 1 ☐ M 2½ ☐ F	7. Age (In yrs.	last birthday) 55 Yrs.	If Under 1 Year Months Days	Hours	Min. 8. C	Date of Birth Month, Day, Yea ug. 22, 1	9. Bir 948 Was	thplace (State or Foreign puntry)
	pu >		Usuel Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation					10d. Inside City Limits
	laryla aho	5		e Georges	100. 01.		ct Heigh	tc				1 ☑ Yes 2 ☐ No
	the N	Director	10e. Street and Number	- 0001905		DISCI	10f. Zip Code	CS		10a	Citizen of What Co	ountry?
	with a or		6325 Foster	Stroot				747				, <u>-</u> , .
	ns 23	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13. V	Was Decedent of H	ispanic Orig	gin? (Specify	Yes or No-	U.S.A.	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f ahow imatic event, the Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☑ Mai 3 ☐ Widowed 4 ☐ Divorce	If Yes, Gir	2 ∑No ve	'	f Yes, specify Cuba 1 ☐ Yes 2 🙀 No	n, Mexican, Specify:	, Puerto Ricai	n, etc.)	Specify:	
ŏ	2 hou	ted		nt's Education		16a. Deced	lent's Usual Occup	ation	of wadda	16b.	Kind of Business	
215	Pin 7	ple	(Specify only night	ost grade completed) College (	1-4or 5+)	life. I	kind of work done of OO NOT use retired	during most	or working			
21	filed with Hygiene. other than	Completed	12			Sal	es Cler				rivate	
nd	d oth	Be	17. Father's Name (First, Middle					18. Mother		st, Middle, Maid		_
yla	should be and Mental I smarked o	ဥ	Harry	Branch							itzgerald	
Mar	0 0 0 0		19a. Informant's Name/Relation Aundre Onley				g Address <i>(Street a</i> Foster S					Zip Code)
	1 and 2 Health tem 27 other tre		20a. Method of Disposition	nasbana	20b. P		sition (Name of natory or other place		Date		Location - City or	Town, State
=			1 Surial 2 ☐ Cremation		State				pr 6 0			
퍨	permit. Page Department of Importent: If any Injury or once.		* 4 □ Donation 5 □ Other (- 21. Signature of Funeral Service		110	_	Mem.Park  Name and Address		pr.6,0		ndover,M	,
Ва	Depart any any any		Francis	B. Him	it		08 Kenne					
			23a. Part1. Enter the disease, of	r complications that	caused the death						LOUIL	Approximate
	Pnysician		shock, or heart failure. Lis Immediate Cause (Final			7						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	rdiac							
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	cuted nd ransi	Examine	that initiated events	С.	abetes							
ó	cate be executed physician and the burial-transit		resulting in death) Last	Due to	(or as a consequ	uence of):						
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9	entific sing p	0 1	IF FEMALE:	220 16 1100 011	toome of presse	1001	- Victorial				awswoodens-	
Вох	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	tcome of pregna pirth 2 ☐ Fetal nant at time of d	I death 3	Ectopic pregnancy Other (specify)				23d. Date of del Month	Day Year
o.	by the destached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn		eath 5	Other (specify)					
<u>α</u>	g g 25		Part II. Other significant condit	ions contributing to d	eath but not res	ulting in the u	nderlying cause givi	en in Part I.		23e. Did tobacc	o use contribute to	the cause of death?
Vital Records,	uires sign	d by								1 🗆 Yes	2 No 3 Pr	obably 4 Unknown
00	w requir been si should I	ompleted								24a. Wasan	24b. Were au	itopsy findings available
Re	The lavate has page 2	щ								autopsy performed	prior to death?	completion of cause of
tal		O	25. Was case referred to medic	al				26. Place		1 ☐ Yes 2 ☐ 1 eck only one)	No I L Yes	2 No
<u>&gt;</u>	S S	O B	examiner? N∑ Yes2 ⊡ No	Hospital: 1 🗆	Inpatient 2 🛭	ER/Outpatien	t 3 DOA Oth	00			6 □Other (Spe	cify)
o of	g Ph ter thi	L:u	27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time of Injury	28c. Injun Worl			Describe how in		
<u>.</u>	Attending I r death. ector: After by the funer	atio	E	igation	,,, Day 1 day	,		Yes 2□N	No			
Division	or Attender de Directo	Certification;	3 Suicide 6 Could 4 Homicide deten	nined 286. Place	of Injury - At ho ing, etc. (Specify	ome, farm, str	eet, factory, office	1.00	28f. L	ocation (Street City or Town, St	and Number or Ru ate)	ıral Route Number,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		ng Physicien: To the I Examiner: On the b and man								
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ı	^ "		DORN	ojalk	ella		00	492	-3		4-1-	04
)· _	(1)		30. Name and address of person Balwant Bagall					e 102	Temple	e Hills	,MD.20748	3
	Sta		31. Date filed (Month, Day, Year	-) A2 F	Registrar's Signa	iture -						
	Registi	rar	APR 062	UU4 ALE	re de	14000						

		1 - For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment <i>tificate</i>	of He	ealth an <i>eath</i>	nd Men	ıtal Hyg	giene <sub>2</sub> ()	04	12815
		1. Decedent's Name (First, Midd	dle, Last)							Date of Dea			3. Time of Death
Phys /Me	ician dica	Bidward Pobort	: Oglio							Month arch 2	Day 200	Year 4	10:51 P M
Exan		4 55 100 44 705 11 10 15		number)		4b. City, To	own, or L	ocation of D			4c. County	of Death	
		5603 Johnson A	Avenue			Beth	esda				Mont	gome	erv
Funer	al	5. Social Security Number	6. Sex	7. Age (In yrs.	, .	If Under 1 Months	Year Days	If Under 24 Hours N		Date of Birth Month, Day		9. Birth	hplace (State or Foreign untry)
Directo	or	220-42-4106	1 M 2 □ F	92	Yrs.					v. 21			York
pug *		Usual Residence of Decedent  10a. State 10b. Count	tv	10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
Aaryla	5												1 ☐ Yes 2 No
the A	Director	10e. Street and Number	gomery	ье	thesda	10f. Zip C	Code	-			0g. Citizen of \	What Co	
with	ءَ ا	5602 Tohmson A						E02					,
If it is within 72 hours after death with the Maryland Hygiene. Hygiene, then "natural", or items 23s or 28s-f ehow ent, it a Madical Examiner must be multiped at	Firmerai	5603 Johnson A	12. Was De	ecedent Ever in U	I.S. 13. V		17-3		? (Specify		United 14. Rac		rican Indian.
fer of	1 2	1 ☐ Never Married 2 ☐ Ma	Armed Armed	Forces? s 2. t√ No		Was Decede f Yes, specif		Mexican, P	Puèrto Rica	n, etc.)		ck, White	
ial', o	2	3 ☐ Widowed 4 🙀 Divorce	I IT YAS. U	GIVE		1 ☐ Yes 2	No.	Specify:			Specify	Wh	ite
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thin thin	100	Elementary/Secondary (0-12)		(1-4or 5+)	life. L	DO NOT use	retired)	ning most of	HOIKING		Feder	al G	overnment
ed wi	غ ا		5+	-	Resea	rch C							
be file tal H doth	a	17. Father's Name (First, Middle	, Last)				1	8. Mother's	Name (Fir	rst, Middle, i	Maiden Suman	10)	
Men Men	F						-		y Che				
2 sh and is m		19a. Informant's Name/Relation									, City or Town,		
s 1 and 2 should be filed within 72 hours after death with the Marylan feelbalth and Mental Hygiene.  1 the left and Mental Hygiene.  1 the left and the marked other than "natural", or items 28a or 28e-1 show other treumatic event, Ira Madical Examinat must be notified at		Elizabeth A.	Hayden/ D		7117 Place of Dispo	River	s Vi	ew Co	urt,				nd 21044
or a see		20a. Method of Disposition 1   Burial 2 □ Cremation	3 Removal from	m State	cemetery, cren	natory or oth	er place)		ril l	0,	20c. Location -	,	
tent:	0	`4 □Donation 5 □ Other (		Hea	aven Gat	Cemete	ery		2004				ng, Maryland
permit. Pages 1 and 2 should be filled within Depriment of Health and Mental Hygiene. Importent: If item 27 is marked other than any rigusy or other treumatic event.	once	21. Signature of Funeral Service	# Linense	M0068	9 Be	thesda thesda thesda	Address a-Che a Ma	of Facility evy Ch arvlar	Rober nase nd 20	t A. Inc. 814-3	Pumphre 7557 W	y Fu	neral Home/ nsin Avenue,
200		23a. Part1. Erre the disease, of sock and failure. Lis	or complications that	t caus of the deat	th. Do not ente	er the mode	of dying,	such as car	rdiac or res	spiratory arr	est,	= 11/1	Approximate Interval Between
Physicia	in -	Immediate Cause (Final disease or condition		teriosc]								1	Onset and Death
/Medic		resulting in death)		to (or as a conseq		Caru.	IUVas	SCULAL	DIS	case			
Examine	er	Sequentially list conditions	b										
D ii	Fxaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consec	uence of):								
ecute and -tran	18	that initiated events resulting in death) Last	C. Due t	o (or as a conseq	uanaa af\:								
cate be executed physician and the burial-transit	TT.		a bus t	0 (01 as a conseq	juence or,								
physicate the last th	i i		d										
death certific attending p	Q.	IF FEMALE:	23c. If yes, o	outcome of pregna	ancv						224 0-4		
Physician: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	e birth 2 Feta	uldeath 3□	Ectopic pred Other <i>(spec</i>					Mo	te of deliv nth	Day Year
the d	No.	1 □ Yes 2 □ No 9 □ Unknown	9□Unk			, Cirior (Spoc	J., J.						
ires that the death			tions contributing to	death but not res	ulting in the ur	nderlying cau	use given	in Part I.		23e. Did tot	acco use cont	ribute to	the cause of death?
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ne la has ge 2	E G									autops	y r		ompletion of cause of
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ysician: The lavins certificate has	000	examiner?	Hospital:	Inpatient 2	ER/Outpatien	00.004	Other			eck only on			
Phys or this oral di	100		28a. Dat	te of Injury	28b. Time of		c. Injury a	4   Nursir		_4	nce 6 Oth		<i>TY)</i>
ding P th. : After s funer	1	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ling (Mo	onth, Day Year)	Injury	М	Work?	s 2 No			, ,		
Attending Ph or death. ector: After th by the funeral	Certification.	3 Suicide 6 Could	d not be 28e. Pla	ce of Injury - At h	ome, farm, stre	eet, factory,	office					er or Rui	ral Route Number,
afte din	T d	4 Homicide	buil	Iding, etc. (Specil	(y)				(	City or Towr	, State)		
To the Hospital or Attendiwithin 24 hours after death. To the Funerel Director: A completely filled in by the fu	Policai	29a. Certifier 1☐ Certify (Checkfort) 2☑ Medica	ring Physician: To the	basis of examina									
thin 2 the	Med	29b. Signature and time of certific		anner stated.		29c. I	License n	number		2:	9d. Date signed	(Month	, Day, Year)
F 3 F 8							D152						
12		30. Name and address of person	n who completed as	use of death /Ita-	n 23a) (Tuna 1		υ1JZ.	0		F	pril 5	, 20	U4
		Carl I. Margol		DME) 111			D + 1.	ro #21	1 R	ockui 1	1 <sub>0</sub> M <sub></sub>	esy1	nd 20052
	State		7) 2004 32.	Degistrar's Signa					.19 200	CKVII	rial ,	утаг	u 20032
	strar	APR 07	2004	Jeneral	Ø	spa	K						

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 28, **Physician** Leif Eric Ottesen 11:59 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 18, 1972 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 XM 2 ☐ F 214-92-1664 Director Maryland Usual Residence of Decedent worle 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehov The Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11400 South Glen Road 20854 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. e filed within 72 hours after Il Hygiene. other than "natural", or Ite 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Poet permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Important: If item 27 is marked other fit any injury or other traumatic event, this once. 2 Creative Writing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eric Albert Ottesen Carole Barbara Vilchis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Barbara Ottesen/Mother 11400 South Glen Road, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State April 4, 2004 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bethesda, Maryland 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licer ee M01353 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) nmediate Cause (Final Physician Multiple /Medical Due to (or as \*\* consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 🗌 Yes 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 2 X No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 28a. Date of Injury (Month, Day Year) March 28, 2004 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 11:45 am 1 Natural 5 Pending trom parking death. 1 ☐ Yes 2 No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office buildin , etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide filled within 24 hours a To the Funeral C 12051 t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd, Rockvii 31. Date filed (Month, Day, Year) gistrar's Signature APR 0 5 2004 Registrar

			Please	State of Maryla				-		•		
			1 - For State Registrar	Otato of Maryto	•	rtificate of		-	Reg. No	-2 n n i	+ 1281	7
			Decedent's Name (First, Middle, La	st)				2. Date of De Month	ath Da	y Year	3. Time of Death	Ť
	Physici /Medio			S. James O	cchipin			March	28	2004	2:00a	И
<i>†</i>	Examin		4a. Facility Name (If not institution, giv				r Location of Death		40	. County of Dea	ith	
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	Funeral Director			ØM 2□F 8		Months Days	Hours Min.	8. Date of Bird (Month, Da April 6	y, Year)	918 Ma	thplace (State or Foreig ountry) ssachusetts	
	D		Usual Residence of Decedent									
	anylar show	7	10a. State 10b. County		City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	the M	Directo	Maryland Montgo	omery C1	arksbur	g 10f. Zip Code			10n. Cit	tizen of What C	ountry?	
	3a or		26401 Forest Vist	Drive			871			ited Sta		
	death	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.		dispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No		14. Race - Am Black, Whi	erican Indian,	_
9	or ite	/Fu	1 Never Married 2 Married	1 XYes 2 No		1 ☐ Yes 2 ☒ No		riidari, etc.)		Specify:		
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7	in 72 in af	olete	15. Decedent's E	ide completed)	(Give	kind of work done  DO NOT use retire	during most of worki d)	ing	100. K	and or business	viridustry	
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9	al Hyg	Be C	17. Father's Name (First, Middle, Last,				18. Mother's Name	(First, Middle,	, Maiden	Sumame)		
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ē,	Health 2 Health 2 tem 27 i		Sandra Occhipinti 20a. Method of Disposition		. Place of Dispo	osition (Name of matory or other place	1	Date		ocation - City or		
ē	Pages nenl of int: If its iry or o		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif				t Cemeter		Dama	ascus. I	Maryland	
Baltimore, Maryland 21	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice				ess of Facility Lesworth					
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Box	certif nding use as	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		<b>7</b> -				23d. Date of de	livery	
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<u>E</u>	nn: Ti iificate or, pa	0	25. Was case referred to medical	ymphocypic		ulemi	26. Place of Death	1 Yes	2) No	1  Yes	s 2□ No	
<u> </u>	ysicii is cer direct	To B	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	nt 3 DOA Oth	ner: 4 🗆 Nursing Ho			6 ☐Other (Spe	acify)	
0 _	ng Ph fter th meral		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time o	f 28c. Inju	ry at	28d. Describe I	how inju	ry occurred		
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Division of Vital Records,	lor At after of Direc J in by	Certification:	4 Homicide determined		ecify)	reet, factory, office		City or Tov			urar Houte Number,	
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	one)	niner: On the basis of exam and manner stated.	ination and/or in					•		
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7			pa M	luck 1	VI	D	19299		Mar	ch 29,	2004	
10	)+1		30. Name and address of person who John Melnick MD			· ·	hura Mar	vland				
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si		Anado	burg, Mal	утанц				_
	Regist	rar	MAR 3 0	2004	of Alexander	THE PERSON NAMED IN						

•	1		for State Registrar	State of Maryland		rtment of			giene 200	4 12818
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last  Elke Elizabeth F  4a. Facility Name (If not institution, give	Post street and number)		4b. City, Town,	or Location of De	2. Date of De Month	Day Year  26 266  4c. County of De.	4 847P M
	Funeral Director		Washington Count  5. Social Security Number  6. Se  600-12-8135  Usual Residence of Decedent		st birthday) Yrs.	If Under 1 Yea Months Days		n. 8. Date of Bir (Month, Da	th y, Year) 9. Bi	inthplace State or Foreign country)
	the Maryland 28a-f show	Director	10a. State 10b. County		Town or Loc New Bri	ghton				10d. Inside City Limits XXYes 2 □ No
036	i within 72 hours after death with the Maryland iene. iene. r than "natural", or liems 23a or 28a-1 show the Medical Evarticer met be rodified at	by Funeral	5 Grove Ave.  11. Marital Status  1 Never Married 2004Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes Cive If Yes, Give Year or Dates:	lf '	10f. Zip Code  1506 as Decedent of Yes, specify Cui	Hispanic Origin? oan, Mexican, Pue	(Specify Yes or No arto Rican, etc.)	Germany  14. Race - Am Black, Wh  Specify: Wh	erican Indian, ite, etc.
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Maryland	2 should be and Mental is marked c	To B	Antonious Custerge 19a. Informant's Name/Relationship (7)		19b. Mailing	Address (Stree		aud Drodo	ofzig er, City or Town, State,	Zip Code)
	es 1 and 3 of Health I item 27 r other tr		David T. Post/Husb 20a. Method of Disposition 1 Burial 2 Cremation 3 DF	20b. Pla	ice of Disposi metery, crema	tion (Name of atory or other pla	асө)	Date	Pennsylvani	Town, State
Baltimore,	permit. Page Department Important; II any injury o		1 4 □ Donation 5 □ Other (Specify) 21. Signature 1 Puneral Service Licens			Cemeter Name and Addr  1 Faste	ess of Facility Do	uglas A.	Wraendorf, FIery Fune Hagerstown,	eral Home
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8760,	Examiner be executed by sician and bhysician and sthe burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ince of):	incere	beal	keur	cliage	8 Hoors
.O. Box 68	death certif e attending id for use a	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Linknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	leath 3□E	ctopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
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of	Phys this ral dii	atlon: To Be	25. Was case referred to dedical examiner?  1 Yes 2 No  27. Manner Death  1 Latural 5 Pending investigation		R/Outpatient 8b. Time of Injury	28c. inju Wo	ner: 4 🗆 Nursing		ne) ence 6 □Other (Spe ow injury occurred	cify)
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Town		
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,	4		Brian H	mpleted cause of death (Item 2:	3a) (Type, Pr	D5	9392		3/27/0	
9	Sta Registr		Brian Holy 31. Date filed (Month, Day, Year) MAR 3 1 2	aes MD 32. Registrar's Signatur	1150	trofess whi	1649/ (	Court	Hagerst 217	foun Mp

			1 - For State Registrar	State of N	Maryland / Depa	artment of H	lealth and I Death		ene g. No. 200	L 12819
			Decedent's Name (First, Middle,	Last)		- Invocato or I	J Guill	2. Date of Death		3. Time of Death
	Physici		Paul Edward I	Palladino,	Sr			Month March	Day Year 2004	
	/Medio Examir		4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death	1	4c. County of De	
	LXamii		Clearview Nurs	ina Home	_	Hag	erstown			shington
	Funeral			. Sex 7. A	Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		irthplace (State or Foreign
	Director		214-09-9231	XXM 2□F	92 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 27, 1	911 Ma	ountry) aryland
	pu		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo					Transit and the
	ehov	5								10d. Inside City Limits 1 X Yes 2 □ No
	the M	Director	Maryland Washii	191011	паде	erstown		140		
	a or	ᡖ	451 East First	C++		10f. Zip Code	04740	10	g. Citizen of What (	,
	eath	era	11. Marital Status	12. Was Deceden	nt Ever in U.S. 13.1	Was Decedent of Hi	21740	pacify Vas or No	US 14. Race - Am	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Exercise Triust be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married  XX Widowed 4 ☐ Divorced	Armed Forego	2 2No	Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 ☐ No	Specify:	Rican, etc.)	Black, Wh	ite, etc.
ŏ	2 hou	Completed by	15. Decedent's		16a. Dece	dent's Usual Occupa	ation	16	6b. Kind of Busines	White s/Industry
215	hin 7	eld	(Specify only highest (Secondary (0-12)	grade completed) College (1-4o	life	kind of work done d DO NOT use retired,	furing most of won )	king		,
7	giene giene er th	Our	12	2		ess Opera	tor		Aircraft	Manufacturer
덜	al Hy d other	Be (	17. Father's Name (First, Middle, La	st)				ne (First, Middle, Ma		
<u>la</u>	Ment Ment arkac	2	Luca Palladi	no			Katheri	ne Mary	Walsh	
lan	2 sho and is my		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	rai Route Number, (	City or Town, State,	Zip Code)
, 2	and ealth m 27		Rose Marie Wing	ert-Daught		Virginia			port,Mary	
altimore,	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from Stat	9	natory or other place	9)		Dc. Location - City o	
ᆵ	tant:		' 4 ☐ Donation 5 ☐ Other (Spe	11 11	Smithsbur	g Cremato	ory Mar.	24,2004 Si	nithsburg	,Maryland
Bai	permit. Pages I Department of H Important: If Ite any Injury or ot		21. Signature of Funeral Service Lig	1 ( ) ( )	0°s	Name and Address	s of Facility neral Hor	ne. P.A.		
_	40344		( any ( )	John -	42	5 S. Conc	ococheagi	ue St. Wi	Lliamspor	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on			er the mode of dying	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
1	Physician / /Medical	1	Immediate Cause (Final disease or condition resulting in death)	-	nous Ly	plule	Lenke	m		3
Ĺ	Examiner		, , , , , , , , , , , , , , , , , , , ,	Due to (or a	s a consequence of):					
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence of):					
	uted Insit	듵	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,					
<u>,</u>	exect n and ial-tra	Examiner	that initiated events resulting in death) Last	c	s a consequence of):					
8760,	cate be executed physicien and the burial-transit	dical		d						
9	tifical ng ph as th	led								
Вох	th cer endir r use	an/A	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom-		Ectopic pregnancy			23d. Date of de	livery
Ш	e dea he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No			Other (specify)			Month	Day Year
P.O.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me	9 Unknown	W. PATER						
S,	signer d be d	þ	Part II. Other significant conditions	Ca Practic		A A CO	n in Part I.			o the cause of death?
Ö	w requir been si should	eted			, cron	> Arres	- Color	1 10 105		robably 4 Olinknown
Vital Records,	ne law has b	효						24a. Was an autopsy performe	24b. Were at	utopsy findings available completion of cause of
<u>=</u>	ician: The L certificate ha rector, page :			7						2 □ No
₹		Be	25. Was case referred to medical examiner?	Hospital:				h Check on one		
o	Phys rthis ral di	2	1 Yes 2 No  27. Manner of Death	28a. Date of Inj		28c Injury	1 4 Hursing Ho	me 5 \(\sum \) Residence 28d. Describe how	e 6 □Other (Spe	ecify)
Division of	Attending r death. actor: After by the fune	후	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Da	ay Year) Injury	28c. Injury Work? M 1 □ Y	? es 2 ⊡No	200. 0000100 11011	injury occurred	
ls!	Attender dear	f ca	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of In	njury - At home, farm, stre			28f. Location (Stree	et and Number or Ri	ural Route Number.
á	a afte	Certification;	4  Homicide	building, e	tc. (Specify)			City or Town, S	itate)	
	To the Hospitel or Attending Phywiting 2 hours after death.  To the Funeral Director: After the completely filled in by the funeral		29a. Certifier 1 Certifying F	hysician: To the best	of my knowledge, death	occurred at the time	e, date and place,	and due to the caus	se(s) and manner as	s stated.
	he Hi in 24 he Fu plete	edical	one)	and manner s	of examination and/or inv tated.	estigation, in my opi	nion, death occur	ed at the time, date	and place, and due	to the cause(s)
	With Com.	Σ	29b. Signature and title of certifier			29c. License			. Date signed (Mont	
	35		- Cont	. ~ 0		0 (3)	् (च	im	IARCH 2	4, 2004
	3		30. Name and address of person wh							
			31 Data filed (Month Day Year)		3 U o M (C		AKERS	to him A	10 21	6 Cm 10
22	Sta Registra	e ar	31. Date filed (Month, Day, Year)	1004 SZ. Hegist	rar's Signature	util .				

State of Maryland / Department of Health and Mental Hygiene 2004 12820 1- State Registrar AMEND TIEM #5 PER INF C841 3/31/05 Continuous of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** NELS FRANKLIN PETERSON 2:50 PM 4 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Worcester Ocean City 423 14th St. Harbor Island If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 11/7/1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X**M 2□F MD 85 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ral', or items 23a or 28a-f shov Examiner must be notified at 1 Xes 2 □ No Ocean City Worcester MD Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 21842 **USA** 423 14th St. Harbor Island permit. Pages 1 and 2 should be filled within 72 hours after death 1 Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 22-any injury or other traumatic access. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★es 2 No If Yes, Give WW 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WWII White 1 Yes 2 XNo Specify: þ If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 NDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Plate Printer Newspaper 12 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mildred Sachs Frank Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28630 Edgemere RD Easton, MD JoAnne Welsh 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 4/5/04 1 Burial 2 Cremation 3 Removal from State Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811 Za. Part 1. Enter the disease, or complications that caused the death too not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MyocARDIAC Physician /Medical Due to (or as a consequence of) PENDENT DIAGETES Examiner Non-INSUL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) THEROSCLENO 820 be executed burial-transit Exami GROMARY Due to (or as a consequence of) Box 68760, the attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I ☐Yes 2☐No s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown Completed 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 certificate 1 Yes 2 No I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 Residence 6 - Other (Specify) 1 □ Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Hamicide within 24 hours a To the Funeral ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 1)4625 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Т. Castaneda, 10324 OLd Ocean City Blvd. Berlin, MD Edwin M.D. 31. Date filed (Month, Day, Year) APR 0 5 32 Registrar's Signature State Registrar

			For State	State of	Marylan	d / Depa	artment of I	lealth and	d Mental Hy		/ 11 11 11	128	121
			Registrar  1. Decedent's Name (First, Middle	Last)			incate or	Death	2. Date of De	Reg. No.		3. Time of	Death
	Physicia		Edward		clati				Month	31.	2004 Yeer	6:00	ам
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, o	or Location of De			County of Deeth	_ 0.00	
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97	Funeral				. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 h	Hrs. 8. Date of Bi	rth ay, Year)	9. Birth	olace (State o	r Foreign
	Director		133-18-8667	12 M 2 L F	77	Yrs.			Oct. 30	0, 19	26 New	York	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation					IOd. Inside Ci	ity Limits
	Manyl f sho ie 1 s	ō	Maryland Mont			Libooto	_					1 🗆 Yes	2 <b>X</b> No
	the rotil	Directo	10e. Street and Number	gomery		Wheato	10f. Zip Code			10g. Cit	izen of What Cou	ntry?	
	death with the Maryland rms 23c or 28a-f show rmust be notified at	al D	2206 Reedie	Drive			20	902			USA		
	deat ams	Funeral	11. Marital Status	12. Was Deced Armed Force		.S. 13.	Was Decedent of I	tispanic Origin?	? (Specify Yes or No uerto Rican, etc.)	0-	14. Race - Americ Black, White,		
õ	or It		1 Never Married 2 X Marri		□No	1	1 ☐ Yes 2 🎛 No		out i nout, oto.,		Specify: White		
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land	uld be Aenta rked tic av	To B	Anthony Par	lati				Mild	lred Forti	unato	)		
Mary	and Name		19a. Informant's Name/Relationsh	iip (Type, Print)		19b. Mailir	g Address (Street	and Number or	r Rural Route Numb	er, City o	r Town, State, Zip	Code)	
Σ.	and and m 27 m 27 ner tra		Sharron Parlati	/ Wife				Drive,	Wheaton,				
e C	If Ita		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from St	C	Place of Dispo cometery, crer te of ]	sition (Name of natory or other pla	се) Арт	ril 2,	20c. Lc	ocation - City or To	own, State	
sammore,	Pag tment tant: jury		' 4 □ Donation 5 □ Other (Sp	pecify)	Gai	Ceme	terv		2004		ver Spri	ng, MD	
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If team 27 is marked other than "natural", or Itams 23c or 28a-f show any injury or other traumatic avant, the Medical Examinating the notified at once.		21. Signature of Funeral Service I	licensee /		$\frac{22}{F}$	Name and Addre	oss of Facility Collin	ns Funera	1 Hor	ne Inc.		
			23a. Part1. Enter the disease, or	complications that cau	ised the death				Lvd. W.,		er Sprin	g, MD 2 Approximate	
١.			shock, or heart failure. List of Immediate Cause (Final	only one cause on eac	ch line.				and or roopinatory o			Interval Bety Onset and D	ween
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9/00	ate the	dical		d									
ο X	ding se a:	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna	ancy					23d. Date of delive	anv	
gox	death of attented for u	Physician/M	in the past 12 months?	4□Pregnar	h 2 ∏Feta nt at time of d		]Ectopic pregnanc ] Other (specify) _	у			Month	,	/ear
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λ, T	requires that the een signed by th nould be detache	by P	Part II. Other significant condition	-		-	, ,			tobacco u	se contribute to the	ne cause of d	eath?
cord	equir en si ould I		Coronary Arter	y Disease,	Perip	hera1	Vascular	Diseas	e 10	Yes 2	X No 3 ☐ Prob	ably 4 🔲	Inknown
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			OH		Death (Check only	one)			
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	ding h. After funer	tion	1 XNatural 5 ☐ Pending		Day Year)	Injury	Wo	rk?  Yes 2 □ No	Zou. Describe	riow injur	y occurred		
DIVISION	Attan deatl ctor: y the	ertification;	3 ☐ Suicide 6 ☐ Could r	ot be	f Injury - At ho	ome, farm, str	eet, factory, office		28f. Location (	Street an	d Number or Rura	I Route Numi	ber,
2	al or / after Dira	erti	4 Homicide	building	, etc. (Specify	y)	, ,		City or To	wn, State	)		
	To the Hospital or Attanding Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.	caic	29a. Certifier 1 Certifyin	g Physicien: To the b Exeminer: On the bas	est of my kno	wiedge, death	occurred at the ti	me, date and pla	ace, and due to the	cause(s)	and manner as s	lated.	
	the H nin 24 the F	fedical	one)	and manne	r stated.	LIIOT ATOO TO			councy at the time,				
	Voirt Corr	Σ	29b. Signature and title of eartifier	1/		X	29c. Licens	se number		29d. Dat	e signed (Month,	∪ey, Year)	
	10+1		1/80	4	$\leq$			046		Ap	ril 2, 2	004	
	•		30. Name and address of person		-			1 D	1 #105	D - 4-1		0001	7
	Sta	te	31. Date filed (Month, Day, Year)	no, Jr., N	1.D. gistrar's Signa				id, #405,	beth	iesda, MI	70817	<u> </u>
	Registr		APR 06	2004	neva	B	board						

			1 - For State Registrar	State of Maryla		artmer		ealth and		ygien Reg. N	_	- 1	128	822
۰Р	hysici	an	1. Decedent's Name (First, Middle, Las	•	. 1				2. Date of D Month	D		Year	3. Time of	Death a. M
	/Medic		Estelle Flyr  4a. Facility Name (If not institution, give		1CK	4b. City.	Town, or	ocation of De	April	7,	200 c. County of		8:10	- A M
	xaiiiii	iei	Manor Care- Po				otoma				Montg		.7	
	ineral ector		Social Security Number		rs. last birthday) Yrs.		r 1 Year	If Under 24 H Hours Mi		irth Da <i>y, Y</i> ea <i>r</i>	)	9. Birthpla Counti	ace (State o ry) esota	
/land	Mo to		10a. State 10b. County	10c.	City, Town or Lo	cation						10	d. Inside Ci	ity Limits
Man	a-f ah ified	tor	Maryland Montgor	nery	Bethesd	a							1 🗌 Yes	2 <b>⊠</b> №
ith the	or 28 engl	Jire	10e. Street and Number			10f. Zip	Code			10g. C	itizen of Wh	nat Count	ry?	
ath w	3 23g	rail	6519 Dalroy Lane				20817			Ĺ,	USA			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	if, or Itams	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 ☐ Yes		panic Origin? , Mexican, Pue Specify:	(Specify Yes or N arto Rican, etc.)	10-	14. Race Black,	White, e	tc.	
2 hou	atura Ical E	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usu	al Occupat	ion	=	16b. I	Kind of Busi	iness/Indu	ıstry	
thin 7	u W	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of wo DO NOT u	ork done du ise retired)	ring most of w	orking				•	
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d 2 sl	traur		Helen P. Varne						Rural Route Num			tate, Zip C	ode)	
of Health a	othar		20a. Method of Disposition	206	. Place of Dispo	sition (Na	me of	1	hesda, I	$\overline{}$	ocation - C	ity or Tow	n, State	
ages ent of	طة ا		1 XBurial 2 ☐ Cremation 3 ☐ 3 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	ate of		other place PN	Apr	il 12, 2004					1
permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene.	Importal any inju once.		21. Signature of Funeral Service Licens		Ceme Fr	Name ar	nd Address S J.	of Facility Collins	Funera	1 Ho	ver S			
Phys			23a. Part1. Inter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused he de one cause on each line.	eath. Do not ent	er the mod	le of dying	such as cardi	ac or respiratory	arrest,	or bp.	1	Approximate nterval Bety Onset and D	e ween Death
	dical niner	_	resulting in death)  Sequentially list conditions.	Due to (or as a cons  b. Urinary Tro  Due to (or as a cons	act Infe	ctio	n						Week	
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ate be execu	physician and the burial-transit	licai Examlner	that initiated events resulting in death) Last	Due to (or as a cons	equence of):							3	lears	
death certific	igned by the attending pr be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pr					23d. Date of Month	,		'ear
The law requires that the	signed b	by	Part II. Dther significant conditions co Atrial Fibrillati		esulting in the ur	nderlying c	ause giver	in Part I.			use contribi			
	should b	iete							24a. Was	e an	24h Wa	re autone	y findings a	wallablo
in: The la	is certificate has director, page 2	e Completed	25. Was case referred to medical					OC Diago of D	auto	ormed? 2 \(\sigma\) No	prid	r to comp th?	letion of ca	use of
yaici	is cer direct	O.	examiner?	Hospital:	☐ ER/Outpatien	t 3□ DC	Other		Home 5 Res		6 ∏Other	(Snecify)		
	r: Atter this ie funeral di	ation; T	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)			8c. Injury a Work?		28d. Describe			(орвону)		
tal or Atta	o the r-unaret Director: Atter the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	et, factory	, office		28f. Location City or To			or Rural F	Route Numb	7e <i>r</i> ,
To the Hospital within 24 hours a	na - unal pletely fill	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred restigation,	at the time , in my opir	, date and place nion, death occ	e, and due to the surred at the time	cause(s date and	) and manned place, and	er as state I due to th	ed. ne cause(s)	
To tha	1	Σ	29b. Signature and title of certifier	PTO	1	290	License i	number		29d. Da	te signed (f	Month, Da	y, Year)	
10	, 0		ramay.	1. Ille			D196	09			April	8, 2	2004	
٠			30. Name and address of person who c											
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			Dr. Raman Tuli 31. Date filed (Month, Day, Year)	10810 Dat					, Gaith	ersbu	ırg, N	1D 20	878	
R	Sta legistr	_	APR 0 9 201		B	Spe	seks							

			. For		aryland / Dep		Health and Me	•	•	
			1 - State Registrar		Ce	ertificate of	Death	Reg	No. 200	4 12823
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Gladys K. Pedapu	ıdi			A	pril 1,	2004	8:44 P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	
			Washington Adven	tist Hosp	ital	Takoma			Montgom	erv
	Funeral		Social Security Number     6. S     1	6ex 7. Ag ☐ M 2 🛣 F	e (In yrs. last birthday	/) If Under 1 Year Months Days		<ol> <li>Date of Birth (Month, Day, Y</li> </ol>	(ear) 9. Bir	rthplace (State or Foreign country)
*	Director		5/8-94-4656	2.00	69 Yrs.			Jan 6, 1		dia
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Manyl f sho	ö	1 1 1		0.11					1 Tyes 2 No
	28e	Director	Maryland Montgo  10e. Street and Number	omery	Silver S	pring 10f. Zip Code		100	. Citizen of What C	ountry?
	3a or	Ö	2216 Condoha Ct				10.7			,
	within 72 hours after death with the Maryland ene. then *netural', or Items 23e or 28e-f show he Medical Examiner must be notified at	by Funeral	3216 Cordoba St  11. Marital Status	12. Was Decedent	Ever in U.S. 13	. Was Decedent of H	104 Hispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No-	U.S.A. 14. Race - Ame	
က္	or Ite	Fur	1 Never Married 2√ Married	Armed Forces?	No			ican, etc.)	Black, Whi	te, etc.
21215-0036	ral', c	l by	3 Widowed 4 Divorced	If Yes, Give X Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	Asian
5-0	72 hc	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dec	edent's Usual Occup	oation during most of working	16	b. Kind of Business	
7	ithin Ne.	nple	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retire	d)	·		
7	filed w Hygier other ti		12		Sec	retary			Nursing	
Maryland	be fi	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma.	iden Sumame)	
7	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	T <sub>o</sub>	Jesudas Kolluri				Kanthamm			
<u>¤</u>	12 st h and 7 ls n traun		19a. Informant's Name/Relationship (1				and Number or Rural			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28e-f show amounts of the real matter of the real matter of the notified at anounce.		Ebenezer Pedapud 20a. Method of Disposition	1/Husband	20b. Place of Disp		St, Silve		MD 2090 c. Location - City or	
ğ	Pages nent of I arry or o		1X Burial 2 ☐ Cremation 3 ☐		cemetery, cre	ematory or other pla	ce)			
Baltimore,	Department Importent:		<ul><li>'4 □ Donation 5 □ Other (Specif)</li><li>21. Signature of Funeral Service Licen</li></ul>		George W	ashington	Cem Apr 7	, 2004	Adelphi,	MD
Ba	Departr Departr Importe any inje		21. Organical Charles	Calbel			ess of Facility Hine			ng, MD 20904
1	190 Alba		23a. Part1. Enter the disease, or comp	plications that caused	the death. Do not er		g, such as cardiac or			Approximate
	District Control		shock, or heart failure. List only	one cause on each	alima	. F 1/2	with.	,		Interval Between Onset and Death
18	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	way na	M El	uyum	19		
₩.	Examiner			Due to (01 as	a diff equents of).	Inmii.	nhat!			
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a compquence of):	corragi	munu	$\int_{\Omega}$	/) 1	
	te be executed ysician and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		- MILKOI	1) 2000	dollo 9	H 0010 1	CYON O	
,60	exec an an rial-tr		resulting in death) Last	Due to (or as	a consequence of):	1			000	
76	te be ysicia ie bui	cal		d	Hypel	lenso				
68	rtifica ng ph as th	Med	TE ETIME		11					
Вох	th cer endir r use	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pregnancy	4		23d. Date of del	livery
	deal ne att	sicie	in the past 12 months? 1 Yes 2 No	4 Pregnant at		Other (specify)	<u> </u>	<del></del>	Month	Day Year
о. О	at the I by the	hy	9 Unknown		-					
Ś	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		Part II. Other significant conditions of	ontributing to death b	ut not resulting in the i	underlying cause giv	en in Part I.		. /	the cause of death?
ord	sen s bluo	Completed	- Havel	201		1161	1.	1 🗌 Yes	2 <b>X</b> No 3□Pr	robably 4 Unknown
Vital Records,	has bo	ple	severe	nei	uhhela	1 Van	Well den	24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
		Con		1		,		performed	death?	·
/ita	cian: ertific octor,	Be (	25. Was case referred to medical examiner?				26. Place of Death (			
	Physician: The la r this certificate has ral director, page 2	ည	1 ☐ Yes 2 X No	Hospital: Inpatie			4   Nursing Home	9 5 Residence	e 6 □Other (Spec	cify)
Ē	ing P	on:	27. Manner of Death  Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28b. Time o y Ye <i>ar)</i> Injury	Wor		d. Describe how i	njury occurred	
Division of	il or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No			
<u>&gt;</u>	after of Direction by	rtif	4 Homicide determined	building, et	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office	28	City or Town, S	t and Number or Ru tate)	iral Route Number,
_	Hospital or Attending Physician: 44 hours after death Funeral Director: After this certifics lely filled in by the funeral director, p		200 Carifier (Carifying Dh	voleion. To the best	-6 l d d		<u> </u>			
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 Certifying Physical Examone)	ysician: To the best niner: On the basis of and manner sta	r examination and/or it	th occurred at the tin nvestigation, in my o	me, date and place, an pinion, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	thin the the sample	Mec	29b. Signature and title of certifier	and manner sta	neo.	29c. Licens	e number	29d.	Date signed (Montl	h Day Year)
					/ -		EL11,5	7	4/9/1	16
	3		30. Name and address of person who d	completed course of it	eath (Item 22c) China	Dont)	2014/		1/4/6	7.
						,	a Davile sm	20010	/ /	
280	Sta	te	Nasreen Kango, M. 31. Date filed (Month, Day, Year)	32. Registra	ar's Signature 🥖	z., Takoma	a Park, MD	20912		
3	Registr		APR 0 7 200	4 Speece	par B	pourker				

			1 = For Stata Registrar	State o	f Marylar		artment o			nd Me	•	_	2004	12	921.		
			1. Decedent's Name (First, Middle, Last)									2. Date of Death 3. Time of Death					
	Physici /Medi		Belle Shenk Pfiester					Month   April					L 4, 2004 Year 4:55 PM				
	Examir		4a. Fecility Name (If not institution, give street and number)					4b. City, Town, or Location of Death					4c. County of Death				
			811 Hillsboro Drive				Silver Spring					Montgomery					
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1	Year Days	If Under 2	Min.	B. Date of Birt (Month, Day	y, Year)		place (State ontry)	or Foreign		
	Director		579-09-0695 Usual Residence of Decedent		85	113.	<u> </u>			Aı	ıg. 30	,191	.8 Wash	ingtor	ı,DC		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury grapher traumatic event, the Madical Examinating in usit by incilling at once.		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside C	ity Limits		
		ģ	Maryland Mont	gomery	erySil			ver Spring						1 🗆 Yes	2 <b>X</b> No		
		Director	10e. Street and Number		10f. Zip Code						10g. Citizen of What Country?						
			811 Hillsboro I	rive			20902						USA				
		Funeral	11. Marital Status	Armed For	dent Ever in U rces?	l.S. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - American Indian, Black, White, etc.				
36		by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv	8		1 ☐ Yes 2X No Specify:					Specify:					
8		ed					ia. Decedent's Usual Occupation						White				
15		plet	(Specify only highest grade completed) (Giv				dent's Osual Occupation 16  b kind of work done during most of working DO NOT use retired)					100. 1	6b. Kind of Business/Industry				
212		To Be Completed	12	College (1	-4or 5+)	Home	maker					0	)wn Home				
2			17. Father's Name (First, Middle,	Last)				-	18. Mother's	s Name (	First, Middle,						
<u>a</u>			Maurice Shenk Rosie Sher								Sherr	r					
Maryland 21215-0036			19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (S	treet ar	nd Number	or Rural F	Route Numbe	r, City o	r Town, State, Zip	Code)			
2			Mark S. Pfiest	er	Son		Ridge		ights				rsburg, N		79		
Baltimore,			20a. Method of Disposition 1   Burial 2 □ Cremation	3 Removal from S	State Par	Place of Dispo Cometery, cred Klawn	sition <i>(Name i</i> natory or othe Memoria	of ir place) a	)	Dat	9	20c. Lo	ocation - City or To	wn, State			
ţ			`4 □Donation 5 □ Other (S				Park		Apr	r. 9,	2004	Roc	kville,M	arylan	d		
Bal			21. Signature of Funeral Service	Licenses			Name and A			ns Fi	meral	Hom	e. Inc.				
			23a Part 1 Foter the disease or	complications that co	used the deat	[50	0 Univ	ers	ity B	lvd.	W.Silv	ver	e, Inc. Spring,				
	Pnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death														
			disease or condition resulting in death)							3 mos							
	Examiner				or as a conseq	•	. 1										
	icate be executed physician and s the burial-transit	Jer	Sequentially list conditions, if any, leading to immediate cause. Lines tribenying Cause (Disease or injury that initiated events	b. Connes	Conrestive Heart Failure  Due to (or as a consequence of):												
		Examiner	Cause (Disease or injury that initiated events														
o	Bon ar	Ex	resulting in death) Last	Due to (d	or as a conseq	uence of):											
8760,	ate be nysici he bu	dlcal		d					<u></u>								
39	e as t	Med	IF FEMALE:	T		10000											
Вох	ician: The law requires that the death certific certificate has been signed by the attending p rector, page 2 should be detached for use as	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir				Ectopic pregnancy				2	23d. Date of delive				
0		Physician/Me	1 ☐ Yes 2 ☒ No 9 ☐ Unknown					Other (specify)				Month			ear		
Δ.		Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?						
Vital Records,		d by	and analysing states growth and									1 ☐ Yes 2 🖫 No 3 ☐ Probably 4 ☐ Unknown					
50		lete															
Re		o Be Completed									24a. Was an autopsy performed? 24b. Were autopsy findings av prior to completion of cau death?				ivallable luse of		
ta			25. Was case referred to medical		20.70						1 Yes 2 No 1 Yes 2 No						
			examiner?														
		-	- I I I I I I I I I I I I I I I I I I I								a Home 5 ☑ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred						
Ö	Attending r death. actor: After by the funer	Certification:	1 XNatural 5 ☐ Pending 2 ☐ Accident investig		nth, Day Year) Injury Work?  M 1 ☐ Yes 2 ☐ No												
Division	or Attencation death	tific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ined 286. Place of	of Injury - At ho	ome, farm, stre	et, factory, off	fice		28f.	Location (St.	reet and	d Number or Rura	Route Numb	oer,		
	spital or Atten ours after deat naral Diractor: filled in by the	Ce	building, etc. (Specify)  City or Town, State)														
	Hospital 24 hours a Funaral I rely filled	edical	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the t Examiner: On the bas	pest of my know	wledge, death	occurred at the	ne time,	date and p	olace, and	due to the ca	ause(s)	and manner as st	ated.			
	To the Hospital within 24 hours a To the Funaral (	Med		and manne	er stated.					000001180	at tire time, de	ate and	place, and due to	trie cause(s)			
	So Just	-	29b. Signature and title of certifier 29c. License number								29	29d. Date signed (Month, Day, Year)					
í	1					1312	D 5	352	8			Apr	il 5, 20	04			
			30. Name and address of person v														
	Sta	te.	Daphna Henkin, 31. Date filed (Month, Day, Year)	32 Ba	309 Sho gistrar's Signat	refield	1 Road	Wh	eator	ı,Mar	yland	209	902				
	Registra		31. Date filed (Month, Day, Year) APR 0 7 2	2004	wa	19	Spark	21									

			1 - For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artment of F	lealth an Death	d Mental Hy	gienę (	004	12825
	Physic /Medi		1. Decedent's Name (First, Middle, La Isadore	ast)	I	Phillip	s		2. Date of De Month APRIL	ath	Yeer	3. Time of Death 2:00 P M
	Exami		4a. Fecility Name (If not institution, gi 6111 MONTROSE RD	,				VILLE		MON	nty of Death	Y
	Funeral Director			Sex 7. 1√2 M 2□ F	Age (In yrs.	92 Yrs.	If Under 1 Year Months Days	If Under 24 H	lin. 8. Date of Bir (Month, Da March4	1912	9. Birthp Coun Massa	lace (State or Foreign itry) achusetts
	Maryland -f ahow	tor	10a. State 10b. County  Maryland Montgon	nery		ty, Town or Lo					10	0d. Inside City Limits
	n with the 3a or 28a	Funeral Director	10e. Street and Number 6111 Montrose Roa	nd, #222			10f. Zip Code 20852	)		10g. Citizen		try?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ahow any injury or other traumatic event, the Medical Examinar runsi he notified at ODGe.	þ	11. Marital Status  1 ☐ Never Married 2  Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1  Yes 2! If Yes, Give	ss? No	ti			(Specify Yes or No erto Rican, etc.)	- 14. R	State Lace - America Black, White, e	an Indian,
21215-0036	d within 72 ho piene. r than "natur the Medical.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-40	or 5+)	16a: Deced (Give i life. L Pharm	ent's Usual Occupa kind of work done of OO NDT use retired	ation during most of v	vorking		Business/Ind	dustry
Maryland 2	ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last Samuel	)	Phi	llips		18. Mother's N	lame (First, Middle,		ame)	
	1 and 2 sho Health and em 27 is m		19a. Informant's Name/Relationship ( Karen P. Freed – I  20a. Method of Disposition		20h F		Whippoor		Rural Route Number	or, City or Tow Lhesda	m, State, Zip (	nd 20852
altimore,	nit. Pages artment of ortant: If it injury or o		1 XBurial 2 Cremation 3 4 Donation 5 Other (Special 21. Signature of Theral Service Lices	<i>y</i> )	.   0	aron Me	atory or other place emorial P	ark 4/9	/2004	Sharon		chusetts
Ba	Per Pep any any	() ()	23a Part 1. Enter the disease, or com shock, or heart failure. List only	Man	ed the deat		TOWGE	T 7.17 T T	dt Funera Rd. Belts	VILLE	Maryl	and 20705 Approximate
İ	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Athero.	SCLONO as a consequ	tie (			la Di			Interval Between Onset and Death
٠,	ficate be executed with physician and street street.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequas a consequ							
.U. BOX 68/60,	death certi e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3 E	Ectopic pregnancy Other (specify)				ate of delivery	y Day Year
S,	igne be d	by	Part II. Other significant conditions o	ontributing to death	but not resu	alting in the und	lerlying cause give	n in Part I.	23e. Did to			cause of death?
Vital Record	The law ate has b page 2 sl	e Completed	26 Was are should be within						24a. Was a autops perform	v I	prior to comp death?	sy findings available pletion of cause of
5	ding Phys h. After this funeral dii	ToB	25. Was case referred to medical examiner?  **Yes 2 \sum No  27. Manner of Death  1 \sum Natural 5 \sum Pending 2 \sum Accident investigation	Hospital: 1 ☐ Inpa 28a. Date of In (Month, D	iury	ER/Outpatient 28b. Time of Injury	3 DOA Other	4 Nursing	Home 5 Reside	nce 6 yOt		SCENE
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	O	3 Suicide 6 Could not be determined	building,	etc. (Specify	·) 			28f. Location (St. City or Town	, State)		J.
	To the Hospital of within 24 hours at To the Funeral Discompletely filled in	Medical	one)	ysician: To the bes liner: On the basis and manner s	oi examinati	wledge, death o ion and/or inve	stigation, in my opi	nion, death occ	e, and due to the caurred at the time, da	ate and place,	and due to th	ne cause(s)
	18 5 18 18 18 18 18 18 18 18 18 18 18 18 18		29b. Signature and fittle of certifier	h l	M		29c. License			9d. Date signe APRIL (		-
	212		30. Name and address of person who come and address of person who come are also as a second and address of person who come are also as a second and address of person who come are also as a second and address of person who come are also as a second and address of person who come are also as a second and address of person who come are also as a second and address of person who come are also as a second and address of person who come are also as a second and address of person who come are also as a second and address of person who come are also as a second and address of person who come are also as a second and address of person who come are also as a second and address of person who come are also as a second and address of person who come are also as a second and address of person and address of person who come are also as a second and address of person and address of person are also as a second and address of person and address of person are also as a second and address of person and address of person and address of person and address of person are also as a second and address of person and address of person are also as a second and address of person are also as a second and address of person are also as a second and address of person are also as a second and address of person are also as a second and address of person are also as a second and address of person are also as a second and address of person are also as a second and address of person are also as a second and address of person are also as a second and address of person are also as a second and address of person are also as a second and address of person are also as a second and address of person are a second and address of person are a second and address of person are a second and address of person are a second and address of person are a second and address of person are a second and address of person are a second and address of person are a second and address of person are a second and address of person are a second and address of person are a second	TAN	death (Item		111 Per		et, Balti	more, l	Maryla	nd 21201
	Stat Registra	~	APR 0 8 200		war a digitali	5	Sparks					

Physician Medical Examiner  RAY E. POWELL, JR.  As a Facility Name (if not institution, give street and number)  3 4250 POWELL ROAD  S. Social Society Number  6. Sex  7. Age (in yrs. last birthday)  10 10 10 11 11 10 11 10 10 11 10 10 11 10 10	3. Time of Death
34250 POWELL ROAD  Functor Director  So Social Security Number  216-14-9599  158 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  109 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  108 M 2 F 81  109 M 2 F 81  108 M 2 F 81  109 M 2 F 81  100 M 2 F	
Director    Page	e (State or Foreign
Second   S	ILLE, MD.
Second   S	1 🗌 Yes 2 💯 No
Elementary/Secondary (0-12)   College (1-4or 5+)   LABORER      College (1-4or 5+)   LABORER	
17. Father's Name (First, Middle, Maiden Sumame)  18. Mother's Name (First, Middle, Maiden Sumame)  19. Father's Name (First, Middle, Maiden Sumame)  19. Father's Name (First, Middle, Maiden Sumame)  19. Father's Name (First, Middle, Maiden Sumame)  19. Father's Name (First, Middle, Maiden Sumame)  19. AGNES MCNEAL  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook  19b. Mary Bould of Date of Disposition (Name of Cook Potential Route)  19a. Informant Number or Rural Route Number or Rural Route Number or Rura	,
RAYMOND DOUGLAS BRADFORD—NEPHEW 34450 POWELL ROAD, PITTSVILLE, MARYLAND 218  20a. Method of Disposition 1	
23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, into the disease or condition resulting in death)  23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Applications of the disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	850
Physician /Medical Examiner  23a. Papr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the line cause on each line.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
	21804  proximate terval Between nset and Death
d	y Year
238. Did tobacco use contributing to death but not resulting in the underlying cause given in Part i.	ause of death?
24a. Was an autopsy f prior to complet death?	etion of cause of
1   Inpatient 2   EH/Outpatient 3   DOA   4   Nursing Home 5   Residence 6   Other (Specify)	
1 Natural 5 Pending investigation 3 O Sourcide 4 Homicide 1 Homicide 1 Natural 5 Pending investigation 3 O Sourcide 4 Homicide 5 Pending investigation 3 O Sourcide 4 Homicide 5 Pending investigation 3 O Sourcide 4 Homicide 5 Pending investigation 3 O Sourcide 4 Homicide 6 Pending investigation 5 O O M 1 Yes 2 No O O O M 1 Yes 2 No O O O M 1 Yes 2 No O O O M 1 Yes 2 No O O O M 1 Yes 2 No O O O M 1 Yes 2 No O O O M 1 Yes 2 No O O O M 1 Yes 2 No O O O M 1 Yes 2 No O O O M 1 Yes 2 No O O O M 1 Yes 2 No O O O M 1 Yes 2 No O O O O M 1 Yes 2 No O O O O M 1 Yes 2 No O O O O M 1 Yes 2 No O O O O M 1 Yes 2 No O O O O M 1 Yes 2 No O O O O M 1 Yes 2 No O O O O M 1 Yes 2 No O O O O M 1 Yes 2 No O O O O O M 1 Yes 2 No O O O O O M 1 Yes 2 No O O O O O O O O O O O O O O O O O O	
29b. Signature and title of certifier  1. Sentity for invalction. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day,	sullemo
H5049) 4/1/04	d. cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Chris Syder D.O. DME 100 E Cavroll St. Salisbury upo 21801  State Registrar  APR 0 1 2004  Server  APR 0 1 2004	d. cause(s)

DRIVIH 17 Hev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 12827 WiCHD, dq Certificate of Death Amend#26,04-13-04,Per Phys 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death Month Estella Parker 21 2004 March 9:20 PM 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 5225 Cooper Road Wicomico Eden If Under 1 Year 5. Social Security Number If Under 24 Hrs 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🔀 F Yrs. 262-26-7556 98 Mar.23 1905 Florida Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Eden Maryland Wicomico 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4490 South Upper Ferry Road 21822 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 **2**No If Yes, Give 1 ☐ Yes 2 XNo Specify: Specify. 3

Widowed 4 □ Divorced Year or Dates Black 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic None 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maude Murray Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Shirley Ducksworth (Giver) 5225 Cooper Rd. Eden, Md. 21822 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 3-24-04 Salisbury, Md. 21. Signature of Funeral Service Licensee 22 Name and Address of Fecility Stewart Funeral Home B West Rd.Salisbury, Md.21801 (D) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TLIYES 281No 1 ☐ Yes 2 ☐ No

**Physician** /Medical **Examiner** or Attending Physician: The law requires that the death certificets be executed

item 27 other t

opartment or Important: If the any injury

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

ahow

r than "natural", or items 23a or 28a-f aho the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours aftar death with the Marylend nent of Haaith and Mantal Hygiene. Int: If Item 27 is marked other than "natural", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

Completed by Physiclan/Medical Examiner Be Medical Certification: To neral Director: A

Division of Vital Records, P.O. Box 68760.

Hospital:

26. Place of Death (Check only one) Caregiver's 1 🔲 Inpatient 4 ☐ Nursing Home Other (Specify) Home 2 ER/Outpatient = 3 = DOA 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 🗆 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 ☐ Suicide 4 ☐ Homicide
29a. Certifier

5 Pending investigation 6 Could not be determined

28e. Date of Injury (Month, Dey Year)

MED

(Check only one)

25. Was case referred to medical examiner?

1 Yes 2 No

27 Menner of Death

1 Natural

2 Accident

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

title of certifier 29b. Signature and

MAR 2 4 2004

of person who is impleted stuse of death (Item 23e) (Type, Print)

29d Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State

32. Registrer's Signature

Registrar

this

within 24 hours a

To the Funeral C

completely filled

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2014 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2004 March 5:30 Р Weldon R. Roberts /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton Nursing & Rehab. Clinton Prince George's Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Yeer) 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 10XM 20 F 83 257-40-8285 Director Feb. ,1921 Georgia Usual Residence of Decedent the Maryland 10a State 10h County 10c City Town or Location 10d Inside City Limits i Hygiene. Jother than "natural", or Itams 23a or 2000. event, the Modical Examiner must be notified at 1 ☑ Yes 2 ☐ No MD Prince George's Director Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9211 Stuart Lane 20735 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Types 2 Tho 12/19. If Yes, Give Year or Dates; 7/02/ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 Never Married 2 Married 12/19/39 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 NWidowed 4 □ Divorced 7/02/45 Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 12 Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) hert. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be unknown unknown ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny Allen/stepdaughter 616 Park Place Deale, MD 20751 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stafe 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Park 03/30/2004 Riverdale, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 21. Signature of Foneral Service License 4111 Farsylvania Ave. Suitland, MD 20746 04 23 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shop, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ad te Cause (Final Physician disease or condition resulting in death) Fatal Cardiac Arrhythmia /Medical Due to (or as a consequence of) **Examiner** Hypertension
Due to for as a consequence of) Sequentially list conditions, If any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year detached for in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did fobacco use contribute to the cause of death? Division of Vital Records, ed bluods 1 Tyes 2 No 3 ☐ Probably 4 X Unknown Stroke peen Skin Cancer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2√2 No Blind Lf. Eye case referred to medical 25. Was case examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpafient Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2XNo 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury af Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 XNafural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 51520 3-25-04 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern Ave. S.E. Washington, D.C. 20032 Bahram Pishdad, M.D. 31. Date filed (Month, Day, Year) APR 0 5 2004 3. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygienes 12830 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Lester Mark ам Raczynski March 29, 2004 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3200 N. Leisure World Blvd., #505 Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 🙀 M 2 🗆 F Months Days Hours Min. Director 018-24-8282 March 24, Poland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 28e-f show 10d. Inside City Limits other traumetic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 1 No Directo Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23a 3200 N. Leisure World Blvd., #505 20906 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: þ Specify: White 3 Widowed 4 Divorced natural Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7: h and Mental Hygiene. 7 Is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) 5+ International Consultant Building & Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Raczynski Jadwiga Skarzynska 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an item 27 ls i Hanna\_Raczynski/ Wife 3200 N. Leisure World Blvd., #500, Silver Spring, MD 2090 20b. Place of Disposition (Name of cemetery, crematory or other place)
Nat'l Shrine of
Our Lady of Czestochowa Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injuryor ot April 3, 2004 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Doylestown, PA 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. mealan 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Privsician disease or condition resulting in death) Cardiovascular Disease /Medical Due to (or as a consequence of) **Examiner** b. Acute and Chronic Myocardial Infarction

Due to (or as a consequence of).

C. Parapleois / C6 Lovel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Feb. 2000 Examine The law requires that the death certificate be executed burial-transit and c Paraplegia/ C6 Level DRoze Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ped f Records, P.O. 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Recurrent Pneumonia, Chronic Lung Disease, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Thoraco-Abdominal Aneurysm Hypothyroidism has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 X No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) dire 2 1 Yes 2 XNo 2 ER/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred 1 Natural 5 Pending after death.

Director: Af
d in by the fur М 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funerel D To the Hospital Medical 29a. Certifier t 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nuerousk MD D23788 March 31, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

32. Registrar's Signature

KP 6111 Executive Blvd, Rockville, MD 20852

Louise Stomierowski M.D.

2004

31. Date filed (Month, Day, Year)
APR 0 7

			For State Registrar	State of Maryla	and / Depa	artment rtificate	of He	ealth an	d Mental Hy	giene Reg. No	2004	12831
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of De Month April		2004 Year	3. Time of Death
	/Medic	al	Saeed Azizi  4a. Facility Name (If not institution, give			4h Cib. T	Taum as	Location of D			County of Deeth	4:15p м
	Examin	er	Holy Cross Ho					r Spr		40	Montgo	
	Funeral		5. Social Security Number 6. S	TT C -	rs. last birthday)	If Under	1 Year Days	If Under 24 I	Hrs. 8. Date of Bir	th av Year	9. Birth	nplece (State or Foreign untry)
	Director		378-78-4298	XM 2□F 58	Yrs.	Wioritis	Days	110013	9/04/	1945	5 Ir	an
	land		Usual Residence of Decedent  10a. State 10b. County		City, Town or Lo							10d. Inside City Limits
	Mary a-f eh	tor	MD Montgom	ery	Brooke	ville	€					1 ☐ Yes 2X No
	or 28:	Direc	10e. Street and Number			10f. Zip (		2		10g. Ci	tizen of What Cou	untry?
	s 23a	rail	19433 Rena Cour		H.P. 40		2083		V(C#-VN		JSA 14. Race - Amer	ing lading
ပ	within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28s-f ehow the Madical Exercitive in ust be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 💽 No					? (Specify Yes or No uerto Rican, etc.)	)-	Black, White	
21215-0036	urel', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 Yes 2		Specify:			Specify: WI	IICe
15. 15.	n 72 h	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual kind of work DO NOT use	k done di	tion uring most of	working	16b. K	ind of Business/li	ndustry
77	l withii liene. r then	omp	Elementary/Secondary (0-12)	College (1-4or 5+)				Manag	er	Αι	ıtomoti	ve
Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified as once.	0	17. Father's Name (First, Middle, Last) Mohammad Sadegh						Name (First, Middle emeh Kar			
lary	2 shou and N is mai		19a. Informant's Name/Relationship (						Rural Route Numb			
	1 and Health In 27		Mary Cecilia A						rt Brool		LIIE, MO	
Do	ages int of h		1 ⊠Burial 2 □ Cremation 3 □  '4 □ Donatiog 5 □ Other (Specify		Place of Dispo cemetery, crei ational							arch, VA.
Baltimore,	mit. P partme sorten / injury		21. Signature Funeral Service Licen									
<u>~</u>	90 E 9		Muly plan	V.	92	241 C	olur	mbia l	Blvd.Sil	ver	Spring	E,P.A. g,Md20910
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the de one cause on each line.						rrest,		Approximate Interval Between Onset and Death
8760,	ires that the death certificate be executed signed by the attending physicien and d be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons  c. Due to (or as a cons  d	equence of):	= =						
.O. Box 68	Attending Physician: The law requires that the death certifica rideath. r death. ector: Affer this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pre Other (spe					23d. Date of deliv Month	very Day Year
٥.	ss that gned by se deta	by Pr	Part II. Dther significent conditions o	ontributing to death but not r	esulting in the u	nderlying ca	use giver	n in Part I.	23e. Did t	obacco (	use contribute to	the cause of death?
ord	w require been signatured should b	ted	Sepsis						_ 10'	Yes 2	□No 3□Pro	bably 4XJUnknown
I Records,	Physician: The law i this certificate has b al director, page 2 st	Completed							24a. Was autor perfo 1 Yes	osy irmed?	prior to co	opsy findings available ompletion of cause of
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Other	*	Death (Check only o			(
Division of Vital	ding Phys I. After this ( funeral dir	lon: To	1 Yes 2 No  27. Menner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time o		3c. Injury : Work?	4   INUISIII	g Home 5 Resident			fy)
Divisi		Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		t home, larm, str cify)				28f. Location ( City or Tox			al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical C	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my k liner: On the basis of exami and manner stated.	nowledge, death	n occurred a vestigation,	at the time in my opi	o, date and plant nion, death o	ace, and due to the courred at the time,	cause(s) date and	and manner as s I place, and due t	stated. o the cause(s)
	To th To th	Me	29b. Signature and title of certifier	Meru	D	29c.	License D3	number 3229			eril 2,	
	1		30. Name and address of person who Ram Trehan MD	completed cause of death (It			kvi	lle Ma	d 20852			
	Sta		31. Date liled (Month, Day, Year)	32. Registrar's Sig	nature /	Soo			_ 20032			
	Registr	ar	APR 0 5 20	34 Sepera	10	1000	2000					

			1 - For State Registrar	State of Mary		artment of H			giene Rog. No. (	2004	12832
	Physici /Medic	- 10	1. Decedent's Name (First, Middle, Last) Indira Ra	o				2. Date of De Month April	Day	Year 2004	3. Time of Death
	Examin		4a. Facility Name (If not institution, give st Shady Grove Advent	ist Hospit		Rockvi			Mor	ounty of Death	у
a	Funeral Director		014-64-0249		yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, De Jan. 3,	th y, Year) 1917	9. Birthp Cour Inc	place (State or Foreign htry) lia
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  Maryland Montgomer		c. City, Town or Lo	nersburg				1	1 ☐ Yes 2√ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 19276 Wheatfield Te	rrace		10f. Zip Code 20879				n of What Coul	,
980	be filed within 72 hours after death with the Maryland stal Hygiene. dother then "natural", or Itams 23a or 28a-f show event, the Medical Erardi of must be notified at	Ď	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	<ol> <li>Was Decedent Ever Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:</li> </ol>		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☑ No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)		. Race - Americ Black, White, pecify: Asia	
Baltimore, Maryland 21215-0036	within 72 ho ene. then "natur ne Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 12		(Give	dent's Usual Occup kind of work done o DO NOT use retired omemaker	during most of wo	rking		of Business/In	dustry
land 2	2 should be filed n and Mental Hygie ' Is marked other reumatic event, II	To Be Co	17. Father's Name (First, Middle, Last) Gopalrao Rao			Smemaker	18. Mother's Nar	ne (First, Middle, Not		ımame)	
Man	and 2 sho aith and 1 27 is mu		19a. Informant's Name/Relationship (Type Rajiv N. Rao / So		1	Mheatfie			-		
imore,	permit. Pages 1 and 2 should by Obepartment of Health and Menta Important: If Item 27 is marked any injury or other treumatic and one.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Montgome	matory or other place ery rium, Inc	200		Bethe	sda, Ma	ryland
Balt	permit. Depart Import any in		21. Signature & Funeral Service License	M0135	6 Be	Name and Addrese ethesda-Cl ethesda, N	ss of Facility Ro hevy Cha Maryland	bert A. se, Inc. 20814-3	7557h 501	wiscons	neral Home/ sin Avenue
8760,	Physician and by sician and by sician and street by sician and street st	dical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Pneumoc Due to (or as a co	Shock	osis ry Distre	ss Syndr	ome			Interval Between Onset and Death
.O. Box 68	at the death certificate be executed by the attending physician and tached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	lc, If yes, outcome of p 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		230	d. Date of delive Month	ery Day Year
<u>α</u>	uires that n signed b lld be deta	by	Part II. Other significent conditions con	tributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did t			he cause of death?
Vital Records,	The law requires that sate has been signed b page 2 should be deta	Completed						24a. Was autop pento 1 🗆 Yes		24b. Were auto prior to co death? 1 □ Yes	ppsy findings available mpletion of cause of
	Physicien: 1 this certificar ral director, p	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: Inpatient	2 ER/Outpatier	nt 3 DOA Oth	ar.	ath <i>(Check only c</i> Home 5 ☐ Resi		Other (Specif	(y)
ion of	Te Te	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Ye	28b. Time o lnjury	Wor	yat k? Yes 2 □ No	28d. Describe	how injury o	occurred	
Division	D it o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm, st Specify)	reet, factory, office	103-2111	28f. Location (. City or Ton		Number or Rura	al Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medicai		ician: To the best of mer: On the basis of ex and manner stated	amination and/or in				date and p	ace, and due to	o the cause(s)
)	Within 50 to the comp	Σ	29b. Signature and title of certifier  Scumo	Khan	vagi	29c. Licens		A		6, 2004	
			30. Name and address of person who con Saima Khamajin, M. 31. Date filed (Month, Day, Year)		ockville		e. 100,	Rockvill	e, Ma	ryland	20852
	St. Regist	ate	APR 0 9 200	4 Sener	a 19	sporks	20				

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month March 2004 ALBERT WESLEY ROBINSON 4:30 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7443 Franklinville Road Thurmont Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last hirthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 220-42-5259 Director 58 June 8, 1945 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits itam 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Mydical Examinar must be notified at Director 1 Yes 2X No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7443 Franklinville Road 21788 U.S.A. death Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 █️No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 by 1 ☐ Yes 2 X No Specity: 3 Widowed 4 Divorced Specify: Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carrier Frederick News Post permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked ofth any intry or other traumatic event, soigs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Albert Robinson, Jr. Goldie Ketterman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhea Eckenrode (Sister) 7443 Franklinville Road, Thurmont, MD 21788 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Prospect Cemetery 4/3/04 4 □ Donation 5 □ Other (Specify Lewistown, Maryland ROBERT E. DAILEY & SON FUNERAL HOMES 615 EAST MAIN STREET, THURMONT, MD 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATIC CANCER **Physician** METHSTANC YEAR resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner be executed the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physiclan/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ٥ in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the a I ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 9q Completed 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 No peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After or Attending Natural 2 Accident 5 ☐ Pending after death.

Diractor: Aft
J in by the fun investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funeral D filled To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical pletely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A31761 and address of person who completed cause of death (Item 23a) (Type, Print) 501 W. SEVENTH ST. O'CONNOR BRIAN M. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 2 2004 Registrar

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		for State	State of Ma	-	epartment of I				1000	
		Registrar		(	Certificate of	Death		g. No. 200L		
Physic	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death	
/Medi		Mary Elizabet		enner			March 27		8:30 A M	
Examir	ner	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town,	or Location of Death		4c. County of Death Frederick		
-g/k-		11009 Haughs Churc		On one to at hinth	Det	Our If Under 24 Hrs.	O Date of Birth			
Funeral		5. Social Security Number 6. Sex 213-24-8697	M 2 F	(In yrs. last birth	Months Days	Hours Min.	8. Date of Birth (Month, Day, 10-17-19	Year) Co	thplace (State or Foreign	
Director		Usual Residence of Decedent		00			10-17-19	/1/ ца	diesburg,MD	
land ow		10a. State 10b. County		10c. City, Town	or Location		-		10d. Inside City Limits	
Mary -f sh	ğ	Maryland Frederic	ck	Detour					1 ☐ Yes 2X No	
r 28a	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?	
3a o	Funeral Director	11009 Haughs Churc	ch Rd.		2175	7		United S	tates	
death	nera	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ame Black, Whit		
or Its	T	1 Never Married 2 Married	Armed Forces?  1  Yes 2  AN If Yes, Give	0	1 ☐ Yes 2 XNo		ritoari, etc.,	Specify: Wh		
ours ours	d by	3 Widowed 4 □ Divorced	Year or Dates:		12.100 222110	oposity.				
72 h	Completed	15. Decedent's Educ (Specify only highest grade	cation e <i>completed)</i>	16a. [	Decedent's Usual Occu 'Give kind of work done life. DO NOT use retire	pation during most of work	cing 1	6b. Kind of Business	Andustry	
ithin and ithin	ldm	Elementary/Secondary (0-12)	College (1-4or 5-	+)				G1 - P		
ied w lygien har ti	S	17. Father's Name (First, Middle, Last)			Seamstre		e (First, Middle, M	Shoe Fac	tory	
be fill be fill be fill be fill be fill be be be be be be be be be be be be be	Be	Elmer J. Moser					3. Coshun			
ally idition at its independent with the Maryland should be filled within 72 hours after death with the Maryland of Mental Hyglene. It marked other than "netural", or items 23e or 28e-f show unatic event, the Medical Expiration could be pullified at	2		ana Printl	10h	Mailing Address (Stree	1			Zin Codel	
VICE 12 St h and 7 is n traun		19a. Informant's Name/Relationship (Ty)							ZIP Code)	
T and leath		Cora Amoss/Daughte	er	20b. Place of	09 Haughs (	Church Rd.		MD 21757 Oc. Location - City or	Town State	
or of or		1 Burial 2 □ Cremation 3 □R	lemoval from State		Disposition (Name of crematory or other plate ope Cemeter					
LIII t. Pa thmer thant thant		'4 □Donation 5 □Other (Specify)		FIL. II		-		woodsboro neral Home	, Maryland	
patitificies, individual ZEC 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28a-1 show any injury or other traumatic event, the Weddeal Examples rough be notified at 2008.		21. Signature of Funeral Service License	1. 11							
2 402 4 4	AT	our They 11	(almo)	the death. Do a	1621 Opos	ssumtown F	ike, Fre	derick MD	21702 Approximate	
		23a. Part1 Enter the disease, or complishock, or heart failure. List only or	ne cause on each line	e.		ing, such as cardiac	or respiratory arres	st,	Interval Between Onset and Death	
Physician		Immediate Cause (Final disease or condition resulting in death)	- HThere	50/2207	ic CAN	-1010 NASCU	/nn 10150	e18e	20 70111	
/Medical Examiner		Tooland and obtain	Due to (or as a	consequence of	f):					
	ē	Sequentially list conditions,	Due to (or as a	consequence of	n:					
ted	nin.	fl any, leading to immediate cause. Enter Underlying Cause (Disease or injury		4						
ou, be executed rcian and burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a	consequence of	f):					
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edic		J							
ath certi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o		_			23d. Date of de	livery	
Beath atter	ciar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	ey		Month	Day Year	
the d	ıysi	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□ Unknown							
that		Part II. Other significant conditions con				ven in Part I.	23a. Did toba	acco use contribute to	the cause of death?	
law requires that as been signed as been signed.	Completed by	Chaosic Obornu	ctive &	MONAL	7 Disens	K	1 🗌 Yes	2 No 3 P	robably 4 Unknown	
w rec	ete			ĺ			24a. Was an	24b. Were au	utopsy findings available completion of cause of	
he la he la g has	шć						autopsy perform	ed? death?		
VICAL ician: T certificate ector, pa	e C	25. Was case referred to medical				26 Place of Door	1 ☐ Yes 2		2 No	
Sicia s cert lirect	OB	examiner?	lospital:	ot 2□EB/Out	patient 3 DOA Ot	tos		ice 6 Other (Spe	cufu)	
DIVISION OF Attending Phy after death. Director: After this in by the funeral of	-	27. Manner of Death	28a. Date of Injury	y 28b. Ti	me of 28c. Inju		28d. Describe hov		Only)	
After a func	i i	1 Natural 5 Pending 2 Accident investigation	(Month, Day	rear) in		Yes 2 No				
Atter dea ctor by the	ifica	3 Suicide 6 Could not be determined			m, street, factory, office		28f. Location (Stre City or Town,	et and Number or Ri	ural Route Number,	
affe affe	Certification:	4 🔲 Homicide	building, etc.	. (Зреспу)			City of TOWIT,	State)		
spita hours inera y fille					death occurred at the t					
n 24 he Fu he Fu	edical	one)	and manner stat		or investigation, in my	opinion, death occur	red at the time, dat	e and place, and due	o to the cause(s)	
To the composition of the the the the the the the the the the	Σ	29b. Signature and title of certifier	/			se number		d. Date signed (Mont		
,		1/ /	om mo			25125		3. 29 0%		
0		30. Name and address of person who co		path (Item 23a) (T	Centre	G. Th	UKMENT	MA	21788	
11.72	ate	31. Date filed (Month, Day, Year)	32. Régistra	r's Signature	pode	/ /				
Regist	rar	MAR 3 0 20	004	as so	5					

			1- For State of Maryland / Depart State of Maryland / Depart Cert	rtment of Health and Mificate of Death	ental Hygie	ne 2004	12836
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medio		JAMES ARTHUR ROBINSON		March 2	Day Year 4, 2004	10:37 P <sup>M</sup>
	Examin			4b. City, Town, or Location of Death		4c. County of Death	
		•	Frederick Memorial Hospital	Frederick		Frederick	
	Funeral Director		5. Social Security Number  6. Sex 12 M 2 F 7. Age (In yrs. last birthday) Yrs.  Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye MARCA 3/	9. Birth Court 930 Flede	place (State or Foreign htry) Puck Co. Md.
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Itams 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be multified at once.	tor	10a. State 10b. County 10c. City, Town or Local Md. Frederick Brunswick				0d. Inside City Limits 1    Yes 2   No
	th the	by Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	23a c	ai D	1100 PEACH ORCHARD LANE	21716		USA	
	ar deg	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. W	as Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Americ Black, White,	
36	s afte	y Fu	1 Never Married 2 Married 1 Yes 2 No	☐Yes 2. No Specify:		Specify: RIA	ngho.
8	hour ture	ed b		nt's Usual Occupation	166	. Kind of Business/In	dustry
15	n ne	piet	(Specify only highest grade completed) (Give ki	nd of work done during most of workin O NOT use retired)	g		
21215-0036	d with giene	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	PACKMAN	1	RAILROAD	
b	a file al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name			
<u>Ja</u>	Menta	To	UN KNOWN	Louise	E Rob	inson	
Maryland	2 sho and lis me			Address (Street and Number or Rural			
	and lealth m 27			BIVENTURE COURT U	-	-	
Baltimore,	ges 1 It of H If ite or ot		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition	itory or other place)		Location - City or To	
ij	t. Pa rtmen rtent: rjury		'4 □ Donation 5 □ Other (Specify)	CREMOTORY 3/20	104 14	AGERSTOUR	ina
Bal	Departiment Important Impo			Name and Address of Facility John			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician	8 (	Immediate Cause (Final disease or condition and the sase of the sase or condition and the sase o	ereorn hem	ORRHHOE	9	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				TO NAME
Á		<b>1</b>	Sequentially list conditions, if any, leading to immediate b. Coker Lopathy				4 DV C3
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	EDADO ADAZTIKAS	CONC	<b>50</b>	YOHRS
	axecu and al-tra	xar	that initiated events resulting in death) Last c.  Due to (or as a consequence of):	TAIL THOUGHT	Chace		1 (111-3
8760,	ate be executed obysician and the burial-transit	ical	d				
9	tificat ng phy as the	ed					
Вох	that the death certif ad by the attending detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ E	ctopic pregnancy		23d. Date of delive	ry
	s deat he att ed for	sicis	1 Yes 2 No 4 Pregnant at time of death 5 C	Other (specify)		Month	Day Year
0.0	at the I by th	Phys	3 - OUKHOWN		T.		
Vital Records, 1	Attending Physicien: The law requires that the death certificate be executed rideath.  r death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burral-transit	þ	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.		o use contribute to th 2 No 3 Prob	e cause of death? ably 4 []Unknown
ecc	e law re has be ge 2 sh	Completed			24a. Was an autopsy	24b. Were autop	osy findings available inpletion of cause of
<u> </u>	ysicien: The is certificate hadirector, page	Com			performed	?   death?	2□ No
/ita	icien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
5	Physic this c	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			6 ☐Other (Specify	)
N C	ding Phy h. After thi funeral	ion	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	3d. Describe how in	jury occurred	
Sic	death death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree	M 1 Yes 2 No	of Location (Street	and Number or Rura	Posto Number
Division of	l or Al after of Direc I in by	ertification:	4 Homicide determined building, etc. (Specify)	t, lactory, office	City or Town, St.	ate)	noble Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edicai C	29a. Certifier  (Check only one)  1  Certifying Physician: To the best of my knowledge, death of the best of my knowledg	ccurred at the time, date and place, ar stigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)
	To the within To the Comple	Me	29b. Signature and little of certifier	29c. License number	29d. I	Date signed (Month, L	Day, Year)
			L. Mejawa MD	116675	r	1ARCH 25,	2004
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	D16675  BRUNSWICK	MD	21716	
	Sta Registr	100	31. Date filed (Month, Day, Year)  MAR 2 9 2004  32. Refistral's Signature	note.			

			For Stete Registrar	State of Maryland		ment of H			ene g. No. 2004	12837
	Physici /Medio		1. Decedent's Name (First, Middle, La	ary Kabi	NSON			2. Date of Death Month MARCA	Day Year Y	3. Time of Death S: 40°PM
	Examin	er	4a. Facility Name (If not institution, given 154 FAIRFIEL  5. Social Security Number 6.5	d DRIVE	F	D. City, Town, or PEOCK Under 1 Year	Location of Death		4c. County of Death	A Chata or Fornian
	Funeral Director		217-10-0575 Usual Residence of Decedent	112M 20F 80	Yrs. M	onths Days	Hours Min.	8. Date of Birth Month, Day, JUNE 5	Year) TURNE	place (State or Foreign ntry) BD Jowy V.A.
	he Marylar 8a-f show clifted at	Director	10a. State 10b. County FREDE	RICK H	Town or Locati	CK				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	sath with the sate or 2	erai Dire	154 FAIR FIEL	12. Was Decedent Ever in U.		10f. Zip Code	a2		g. Citizen of What Cour	4.
920	72 hours after death with the Maryland neturel', or Items 23e or 28a-f show diest Examinat must be rodified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:	If Ye	Yes 2 No	spanic Origin? (S) n, Mexican, Puert Specify:	Decity Yes of No- Decity Yes of No- Decity Yes of No-	14. Race - Americ Black, White, Specify:	
21215-0036	be filed within 72 hours after death with the Marylan Ital Hyglene. od other than "neturel", or Items 23e or 28a-f show event, the Madical Examinar must be rediffed at	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give kind	's Usual Occupa d of work done d NOT use retired;	lurina most of wor	king 1	6b. Kind of Business/In	dustry
	should be filed value and Mental Hygie marked other tumatic event, to	To Be Co	17. Father's Name (First, Middle, Last HOUARD HEW)	ey Robinso		INC OF	18. Mother's Nam	ne (First, Middle, M	aiden Sumame)	
, Maryland	d 2 shouth and N		19a. Informant's Name/Relationship (	Турв, Print) D	19b. Mailing A	AIRFIE	and Number Ru	ral Route Number, FRED. /	City or Town, State, Zip	Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Special	Removal from State	ace of Disposition  metery, cremato  RVIEW	on (Name of any or other place CEM:	3-3	0-04 /	Oc. Location - City or To NEDERIC	1
Balt	Depart Depart Import eny in		21. Signature of Funeral Service Lieu	w	110	ame and Address	ceth 5	T. Fres.	ms. 2170	gal None
	Physician /Medical		23a. Part1. Enter t i disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aCount	y au		che ce as cardiac		st,	Approximate Interval Between Onset and Death
	Examiner	eľ	Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause, (Disease or infjury	b. Due to (or as a consequ		U				
oʻ	ate be executed thysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of);					
κ 68760,	9 4 10	Medical	IF FEMALE:	_ d					-	
P.O. Box	res that the death certifigned by the attending be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ect	opic pregnancy ner (specify)			23d. Date of delive Month	Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of		Iting in the under	lying cause give	n in Part I.		cco use contribute to th	
Vital Records,	The ate h page	Completed						24a. Was an autopsy performs	prior to cor death?	psy findings available appletion of cause of
Vita	ysiclen: The Is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:				h (Check only one)		
ō	Attending Physicien: r death. ector: After this certifici by the funeral director,	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	28c. Injury Work	at ? es 2 □ No	ome 5 Residen 28d. Describe how	ce 6 Other (Specify injury occurred	9
Division	i Pite	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	6 One Blace of laiver At her	me, farm, street.		03 2	28f. Location (Stre City or Town,	et and Number or Rura State)	Route Number,
	he Hospitel n 24 hours a he Funeral I	edical	29a. Certifying Ph (Check only one)	iysicien: To the best of my know niner: On the basis of examinati and manner stated.	vledge, death occion and/or investi	curred at the time gation, in my opi	e, date and place, inion, death occur	and due to the cau red at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
•	To the within 2 To the complete	M	29b. Signature and title of certifier MD	,		29c. License	number 5463	290	. Date signed (Month, L	Day, Year)
	6		30. Name and address of person who	gue 700	Mon-	tclair	e Ave.	Frede	rick Ma	121701
100	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure	South !				

		For State Registrar	State of M	Maryland / D		artment of rtificate or			nental Hyg	giene Reg. No.	200	4 12838
Physicia /Medica Examine	al	Decedent's Name (First, Middle, Louis Schwartz     Schwartz     Fecility Name (If not institution, girmanor Care)		r)		4b. City, Town, Bethe		n of Death	2. Date of Dea Month March	Day	3. Time of Death 11:47 PM eth omery	
Funeral Director		5. Social Security Number 6.  121-07-9431  Usuel Residence of Decedent	Sex 7. A 1 ☑ M 2 ☐ F	Age (In yrs. last birth 85 Yı	day) rs.	If Under 1 Yea Months Days			8. Date of Birth (Month, Day December		9. B 918 Ne	irthplace (State or Foreign Country) BW York
e Maryland	Director	10a. State 10b. County Maryland Montgome	ery	10c. City, Town Bethes								10d. Inside City Limits 1 ☑ Yes 2 ☐ No
th with th		10e. Street and Number 5903 Woodacres Di	rive			10f. Zip Code	20816				zen of What ( ted St	•
S	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 Yes 25 If Yes, Give Year or Dates	₹No		Vas Decedent of f Yes, specify Cu □ Yes 2⊠ No			ecify Yes or No- Rican, etc.)		Black, Wh	nerican Indian, nite, etc. Nhite
Z IZ IS-0036 d within 72 hours at giene. or than "netural; or tre Medical Exerci-	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation a de completed)  College (1-40)		Give . life. [	ient's Usual Occu kind of work done OO NOT use retin	durina me	ost of work	ing		nd of Busines	s/industry
Maryland 2  Maryland 2  Maryland Mental Hygi  Maryland Mental Hygi  Maryland Mental Hygi  Maryland Mental Hygi  Maryland Mental Mental Hygi  Maryland Mental	To Be Co	17. Father's Name (First, Middle, Las Charles Schwar	tz			corner	18. Mot		e (First, Middle, I	Maiden		
and 2 sho and 2 sho lealth and m 27 is m		19a. Informant's Name/Relationship Michael Schwartz		59	903	g Address (Stree Woodac						Zip Code) 0816
Dallimore, Demit. Pages 1 a Department of Hea mportent: If item any injury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 [  '4 ☐ Onation 5 ☐ Other (Special Service Lice)	<i>fy</i> )	20b. Place of D cemetery, Geo. Wa Medica	crept ash al	univer Center				Was	hingto	on, D.C.
Deparing Department of the partment	Dur X	ede		P	Name and Addr Columbia .O. Box	_5800	7 Was	hington	. D.	nc. C. 200	37	
Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	ad the death. Do not line.  SAPSIS s a consequence of)				s cardiac d	or respiratory arro	est,		Approximate Interval Between Onset and Death
te be ysicie	Ical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	s a consequence of)	:	<i></i>	77د					/mo
death certif		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  yes 2 No 9 Unknown		e of pregnancy 2  Fetal death at time of death		Ectopic pregnand Other (specify)	у			2:	3d. Date of de Month	olivery Day Year
igne ligne	2	Part II. Other significant conditions of the CA	contributing to death	but not resulting in th	10 un	derlying cause gr	ven in Part	l.		acco us		o the cause of death?
	completed	Athero Schu dementia	osis						24a. Was ar autops perform 1 Yes 2	red?	prior to death?	utopsy findings available completion of cause of
ing Physici ling Physici After this cer uneral direc	0	25. Was case referred to medical examiner?  1	Α	ury 28b. Tim ay Year) Inju	e of ry	28c. Inju. Wo M 1	ner: 4 🕡 🗸	ursing Hon 2	(Check only one ne 5 ☐ Reside 8d. Describe ho	nce 6 w injury	occurred	
Hospitel or Attend 1.24 hours after death Re Funerel Director: Julian in by the footstilloot		4 Homicide determined	building, e	jury - At home, farm, tc. (Specify) of my knowledge, d	eath	occurred at the to	me date a	nd place, a	City or Town,	, State)		ural Route Number,
To the Hosp within 24 hou To the Fune completely fil		(Check only 2 Medical Example)  29b. Signature and title of certifier	niner; On the basis of and manner st	n examination and/o	r inve	29c. Licens	pinion, de	ath occurre	29	te and p	signed (Mont	h. Day, Year)
. State		30. Name and address of person who  Lila T. McConn  31. Date filed (Month, Day, Year)  APR 0 5 200	nell, M.D. 32. Registi			rint)	enue					ase,MD 20815

			For State Registrar	State	of Maryland		artmen rtificat				Reg. No	200	4 12	830
	Physicia	an	Decedent's Name (First, Middle     BELVA MARTHA	e, Last) STOUFFER						2. Date of D	Da			
	/Medic	al	4a. Facility Name (If not institution		ımber)		4b. City.	Town, or	Location of Dea	March		2004 c. County of De	1:25	РМ
	Examin	er	REEDERS MEMORIA		,		,,		ONSBORO			•	SHINGTON	V
رق	Funeral Director		5. Social Security Number 215–26–8989	6. Sex 1 ☐ M 2 【X F	7. Age (In yrs. Ia 72	rst birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min				irthplace (State o Country) MARYLAN	r Foreign VD
A.	show		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside Ci	ty Limits
Stout AG	72 hours after death with the Maryland natural", or Items 23a or 28a-f show Jeel Examitter met be mulfied at	Funeral Director	MARYLAND WA	ASHINGTON			10f. Zip		OONSBORO		10a. Ci	tizen of What (	1 Tes	2 XNo
4 )	23a or	i Dir	6239 APPLETOWN	ROAD					21713				J.S.A.	
5	ems 2	iner	11. Marital Status	Amed F	edent Ever in U.S	3. 13.	Was Deced	dent of Hi	spanic Origin? (	Specify Yes or Note (Note )	0-	14. Race - An Black, Wh	nerican Indian,	
umme 15-0036	rs afte	οy Fι	1 ☐ Never Married 2 Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 ☐ Yes	2 X No		1 ☐ Yes		Specify:			Specify:	WHITE	
mm6	72 hours natural', licul Ex	Completed by	15. Deceder	t's Education		16a. Dece	dent's Usua	al Occupa	ation	odina.	16b. K	(ind of Busines		
$\int_{\mathcal{U}}$		npie	Elementary/Secondary (0-12)	st grade completed, College	(1-4or 5+)	life.			furing most of wo	nkuig		07.77		
		Co	17. Father's Name (First, Middle,	Last)			H(	)MEM/		me (First, Middle	. Maider	OWN	HOME	
/A land	be d la be	To Be	LESTER SUMMERS							HOFFMAI		, , , , , , , , , , , , , , , , , , , ,		
ary	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a	and Number or R	ural Route Numb	er, City	or Town, State	, Zip Code)	
B, N	1 and 1ealth 3m 27 ther tr		MARVIN P. STOUT	FFER, HUS						BOONSBO	_	MARYLA ocation - City of		L3
nor			1 ☐ Burial 2 ☐ Cremation  '4 ☐ Donation 5 ☐ Other (5		Jale	ace of Dispo metery, crer NEVOLA			1	02/2004			, MARYLA	NT)
ame Baltim	permit. Page Department of Importent: If any injury or ance.		21. Signature # Funeral Service		Dia				s of Facility			NATIONA		מות
38	F 0 F 8 8		Preziva. Z	mmerman	_	I	AST I	UNE	RAL HOME			, MARYI		713
<	Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on	caused the death. each line. NEUYNO	•	er the mod	e of dyin	g, such as cardia	c or respiratory a	arrest,		Approximate Interval Bety Onset and D	ween
	/Medical Examiner		resulting in death)		(or as a conseque		Λ.		•				4WKS	
	Examiner	-e	Sequentially list conditions, if any, leading to immediate	b. Due to	(oras a conseque	ence of):	Dev	nen	ria				years	- /
3760,	Attending Physician: The law requires that the death certificate be executed reash.  reach: sector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to	(or as a conseque	ence of):								
39 x	eath certifica attending pt i for use as t	/Med	IF FEMALE:	23c If yes or	atcome of pregnan	icv						004 0-1	-15	
P.O. Box 68760,	that the death of the attended by the attendetached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	birth 2 ☐ Fetal on mant at time of dea	death 3□	Ectopic pr Other (sp					23d. Date of d Month		'ear
	es that ti gned by be detac	by Pr	Part II. Other significant conditi			ting in the u	nderlying c	ause give	en in Part I.	23e. Did	tobacco	use contribute	to the cause of de	eath?
ords	v requires been signs should be	ted	m	alnutrition hydration	ימכ			-		10	Yes 2	<b>25N</b> o 3□ 8	Probably 4 □U	Inknown
Rec	The law a cate has be page 2 sh	Completed	De	hydratio	o n						psy prmed?	prior to death?		available ause of
Ital	ician: Th certificate ector, pag	Be Co	25. Was case referred to medica	1					26. Place of De	1 ☐ Yes ath (Check only	2 No one)	1 □ Y€	es 2 No	
> _	Physici this ce al direc	To E	examiner? 1  Yes 2 No			R/Outpatier			4 Nursing i	T*		6 □Other (Sp	ecify)	
on G	tending Physician: feath. tor: After this certific the funeral director,		27. Manner of Death	'9	of Injury oth, Day Year)	28b. Time of Injury	M 2	8c. Injury Work	at :? ∕es 2 ∐ No	28d. Describe	how inju	ry occurred		
Division of Vital Records,	or Attendiater death. Director: A in by the fu	Certification;	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	e of Injury - At hon ling, etc. (Specify)				2 110	28f. Location ( City or To			Rural Route Numb	ber,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	edical Ce		ng Physicien: To th Exeminer: On the l and mar										
	To the within 2 To the complet	Me	29b. Signature and title of certifie	1)_				. License				te signed (Mor		
	n		14	1				449	96		Mon	ch 29,	,2004	
<b>)</b>	H,		30. Name and address of person Dr. Zafar Malik					oro	Marylar	nd 21712	/ 2	01_//32	9/170	
	Sta	te	31. Date filed (Month, May, Deag	1 000 4 32.1	Registrar's Signatu		1 . 1	<u>ر ۱۰</u>	mar y rar	10 51/13	, 3	01 <b>-</b> 436-	-0470	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2001

		A B			Cert	iticate	of Death		Reg. N		
	Physician /Medical	1. Decedant's Nama (First, Mid Gladys Mary St						2. Data Monti		<sup>ey</sup> 200	3. Time of Dea 03:25
N. Carlotte	Examiner	4a Facility Nama (If not instituti Coffman Nursin		ber)				own, or Locetion of C Stown		c. County of De Washing	
Ī	Funeral Director	5. Social Sacurity Numbar 214-09-0787	6. Sax 7 1  M 2	7. Aga (In yrs. Ia 94	st birthdey) Yrs.	If Undar 1 Y Months Da		Min. 8. Data (Mont.	of Birth h, Dey, Yee 0/1909	9. E	Birthplaca (State or Fo Country) PA
	pue *	Usual Residence of Decedent  10a. State 10b. Count	<b>V</b>	10c City	Town or Loca	ntion					10d. Inside City Li
	Maryland and and and and and and and and and		ngton	1	gerstov						1 □ Yas 2½
	after death with the Ma w items 23s or 25s-fs riner must be notified Funeral Director	10e. Street and Number 18209 Showalte	r Road			10f. Zip Cod 2174				itizen of What	Country?
020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Manylend Dependment of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examinar must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 1 □ Navar Marriad 2 □ Ma 3 ☑ Widowed 4 □ Divorce	Armed Ford	2 🔯 No	If '	as Decedant ∕as, specify ( ☐ Yas 2፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟፟	Cuban, Mexica	rigin? (Spacify Yas o an, Puarto Rican, ato v:	or No-	14. Race - Ar Black, Wi Specify: V	_
Maryland 21215-0020	be filed within 72 hours it tal Hygiene. d other than "natural", c event, the Mudical Exar Be Completed by	15. Daceda (Specify only high Elamentery/Secondary (0-12) 12	nt's Educetion est grede completed)  Collaga (1-4	4or 5+)	16a. Daceda (Give ki life. Do Secreta	nd of work do NOT use re	ccupation one during mo atired)	st of working		Kind of Busines	ss/industry
yland	Mental Hyg Mental Hyg Brked othe atic event,	17. Fathar's Nema (First, Middle Richard (unk)						nar's Name <i>(First, Mi</i> 7 Ellen Sr		n Sumame)	
Mar	d 2 sh dh end 7 te m treum	19a. Informant's Name/Relation M. Ellen Duffe			_			per or Rurel Route N 11, Harri			
<u>a</u>	f Heali f Heali ftem 2	20a. Method of Disposition		20b. Pla	ce of Disposi			Date		ocation - City	-
Baltimore,	Pege ment c	1 ☐ Burial 2 【② Cramation 4 ☐ Donation 5 ☐ Othar (		tate	hsburg	Crema	atorium	03/31/0	4 Smi	thsburg	g, MD
Dai	permit. Depert Import any Inj price.	21. Signature of Funeral Service	Licensaa	2	22. 1	lama and Ad	ddrass of Facil	Gerald Street, H	N. Mi	nnich F	uneral Hor
8760,	ficete be executed  physician and street burief-transit  the burief-transit  edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequantially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disease or injury that initiated avants rasulting in death) Last	a	,	as a conseque s a conseque s a conseque		9			7	Onset and Death
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s, P.O.	The law requires that the death certificate the been signed by the ettending page 2 should be deteched for use escompleted by Physician/Me	Part II. Other significent conditions of the significant condition	ions contributing to deal		ng in tha und	arlying cause	given in Pert				ta to the cause of de Probably 4 🗆 Unki
Vital Record	the law require cate has been sign, page 2 should the Completed								Ves an auto erformad?	opsy 24b	. Were autopsy findin available prior to completion of cause of death?
	ictan: The li certificate he rector, page	25. Was case referred to medical					OC PI		□Yes 2	JN₀	1 ☐ Yes 2 ☐ No
>	hysician nis certifi il director	examiner?	Hospital:	oatient 2 EF	₹/Outpatient	3□ DOA	Out	e of Death <i>(Check o</i> ursing Homa 5 🗆 F		6 □Othar (Sp	pecify)
lon or	After ti funera	27. Manner 1 ath 1 atural 5 Pandi 2 Accidant invast	28a. Data of (Month, igation	Injury 20 Dey Year)	8b. Tima of Injury		njuryat Work? I∐Yes 2∐	28d. Dascr	ibe how inju		
		3 ☐ Suicida 6 ☐ Could 4 ☐ Homicida detarr	mined 20d. Flace U	f Injury - At home, atc. (Specify)	e, farm, straa	, factory, offi	Се	28f. Location City on	on (Street ai Town, State	nd Number or F e)	Rural Route Number,
	Hosp 24 hour Funer stely fil	29a. Certifier 1 ☐ rtifyi (Check only one) 1 ☐ Medicat	ng Physicisn: To the be t Examiner: On tha basi and manna	is of axamination	edge, death on and/or inves	ccurred et the tigation, in m	e time, data en ny opinion, dea	nd place, and dua to ath occurred at the ti	the cause(s me, date an	) and manner a d place, and du	as stated. ue to the ceuse(s)
	within Comple	29b. Signature and titla of certific	Chow, m	D		29c. Lic	ansa number		29d. Da	ita signad (Mor	2004
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	30. Nama and address of person	who completed cause	of death (Item 2	3e) (Type Pr	nt)	An.	08 / /	4. )	7,21/	(,)

Decoder's Name (Frost, Microb, Last)   Thomas Henry Shank   2. Date of Death March 29 700A   9:00A   9:00A   4. Cety, Town, or Location of Death March 29 700A   9:00A   4. Cety, Town, or Location of Death Aval on March 29 700A   9:00A   4. Cety, Town, or Location of Death Aval on March 29 700A   9:00A   4. Cety, Town, or Location of Death Aval on March 29 700A   9:00A   4. Cety, Town, or Location of Death Aval on March 29 70A   9:00A   4. Cety, Town, or Location of Death Aval on March 29 70A   9:00A   4. Cety, Town, or Location of Death Aval on March 29 70A   9:00A   9:00A   7. Age (for yet, last bethody)   1. Thomas Microb 29 70A   9:0				For State Registrar	State of N	Maryland / D	epartme Certifica	ent of Heate of L	ealth and Death	Mental Hy	giene ,	2004	12841
44 Sealer hereof internations are considered and numbers of the control of the co	_		n	1. Decedent's Name (First, Middle, L						Month	ath Day		
Social Security Number   2			- 0	4a. Facility Name (If not institution, g	ive street and numbe	•	4b. Ci			ath		ounty of Death	1
100. Size of the Number   100. Courty   100. College (1 For 5)   100.				217-30-6114			Month	der 1 Year	If Under 24 H	rs. 8 Date of Bir	th ly. Year) , 1934	9. Birth	place (State or Foreign
The state of the s	the Maryland	routies at	rector	10a. State 10b. County  Maryland Wash	ington	10c. City, Town	Hagei				10g. Citize	en of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☑ No untry?
The state of the s	U36 ours after death with ral', or Itams 23a or	Examiner musice	by Funeral	11. Marital Status 1 □ Never Married 2 Married	12. Was Deceder Armed Force 1  Yes 2	nt Ever in U.S. §? () No	If Yes, s	cedent of His pecify Cubar	panic Origin? i, Mexican, Pue	(Specify Yes or No arto Rican, etc.)		4. Race - Amer Black, White	ican Indian, , etc.
Physician Medical Examiner  Physician Medical Examiner  Physician Medical Examiner  Physician Medical Examiner  Personal Examiner  Physician Medical Examiner  Person	d 21215-U	ent, the Madical	e Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4o	(	Give kind of life. DO NO	work done di ruse retired) orema	uring most of w		Labe	l Manuf	ndustry
Physician Medical Examiner  Physician Medical Examiner  Physician Medical Examiner  Physician Medical Examiner  Personal Examiner  Physician Medical Examiner  Person	Marylan d 2 should be th and Mental 7 is marked c	traumatic ev	0	19a. Informant's Name/Relationship	(Type, Print)		_	ess (Street a	Hele	n Chris	tina er, City or	Helshe Town, State, Zi	p Code)
Physician Moderal Examiner  Physician Medical Examiner  Ph	Pages 1 and ment of Healt	ury or other	-	20a. Method of Disposition  XXBurial 2 □ Cremation 3	☐Removal from Stat	20b. Place of I cemetery	Disposition (No. ), crematory of	lame of it other place	)	Date	20c. Loca	ation - City or T	own, State
Physician Middical Examiner  The Company of the Com	Dermit Depart Import	any in		> Mastin-	Cru_		425 S.	Conoc	cocheag	ue St. W	illia	msport,	
Sequentially list conditions a consequence of):  Due to (or as a consequen	/Medi	cal		shock, or beart failure. List on Immediate Cause (Final disease or condition	y one cause on each	TICOBVI	BEN	20	ECENI	ERATIO	W		Interval Between
FEMALE:   23d. Date of delivery   23d. Date of deliv			icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	as a consequence of	):	EART	- FA	LURR			2×
1   Yes   2   No   3   Probably   4   Qúnknown   24a. Was an autopsy performed?   1   Yes   2   No   3   Probably   4   Qúnknown   24b. Was an autopsy performed?   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   Yes   2   No   Yes	the death certificative the attending ph	ched for use as the	ysician/med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant	2 Fetal death at time of death					23		- ,
25. Was case referred to medical examiner?  1   Yes   Yes   No    26. Place of Death (Check only one)  27. Manner of Death   Yes   Y	quires that	2 .	2	Part II. Other significant conditions	contributing to death	but not resulting in t	he underlying	g cause giver	n in Part I.		_		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Khalid M. Waseem, M.D. 1126 Opal Court Hagerstown, Maryland 21742	The taw recate has bee	age 2								autop perfo	rmed?	prior to co death?	mpletion of cause of
29a. Certifier (Check only one)  29a. Signature and title of certifier  29b. Signature and dudress of person who completed cause of death (Item 23a) (Type, Print)  Khalid M. Waseem, M.D. 1126 Opal Court Hagerstown, Maryland 21742	VIII /sicien	lirector	0	examiner?	Hospital:	tient 2 FR/Outr	atient 30	Othor				Other (Specif	6.1
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Khalid M. Waseem, M.D. 1126 Opal Court Hagerstown, Maryland 21742	ION OF	e tuneral c		27. Manner of Death 1 Satural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Tir	ne of ury	28c. Injury a Work?	at _				<i>y)</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Khalid M. Waseem, M.D. 1126 Opal Court Hagerstown, Maryland 21742	DIVIS tal or Atters after dezerte	ed in by th	Certifica	3 ☐ Suicide 6 ☐ Could not	d 286. Place of I	njury - At home, farn etc. <i>(Specify)</i>	n, street, fact	ory, office	7/7///			Number or Rure	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Khalid M. Waseem, M.D. 1126 Opal Court Hagerstown, Maryland 21742	he Hospi n 24 hour he Funer	pletely til	edical	(Check only 2 [ Madical Exa	aminer: On the basis	of examination and/	death occurre or investigation	ed at the time on, in my opi	, date and place nion, death occ	e, and due to the curred at the time,	cause(s) ar date and pl	nd manner as s lace, and due to	tated. o the cause(s)
		woo :	Ξ		mes							-	Day, Year)
11 1 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	AL.	Stat	1	Khalid M. Wasee	em, M.D.	1126 Opal		Hager	stown,N	Maryland	2174	2	

			State Registrer	te of Maryland	d / Depa	ırtme		ealth and			2001	12842
			1. Decedent's Name (First, Middle, Last)	-					2. Date of Dea	ath		3. Time of Death
	Physici /Medic		Jane Elizabeth Sh	nank					Month	Day	Year	1 822 PM
	Examir		4a. Facility Name (If not institution, give street a	nd number)		4b. City	, Town, or	Location of De	ath	4c.	County of Dea	ith
			Washington County H	<del></del>			Ha	gersta			Wash	nington
	Funeral		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. I	ast birthday) Yrs.	Months Months	Days	Hours Mi	n. (Month, Da	th y, Year)	_   0	thplace State or Foreign ountry)
	Director		Usual Residence of Decedent	81	113.				Dec.20	, 192.	2 N	laryland
	yland pow		10a. State 10b. County	10c. City	, Town or Loc	cation						10d. Inside City Limits
	Mar Mar	tor	West Virginia Berkeley			Fa	alling	y Water	s			1 Yes 2 No
	or 28	lre	10e. Street and Number	· ·		10f. Z	p Code			10g. Citi	izen of What C	ountry?
	23a	ral	205 Jamestown Drive	9			2	5419			USA	
	tems	Funeral Director	Arm	Decedent Ever in U.S ed Forces?	S. 13. V	Vas Dece Yes, spe	edent of His	spanic Origin? n, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)		14. Race - Am- Black, Whi	
36	rs afte	by F	If Yo	Yes 2/∰No es, Give rorDates:	1	☐ Yes	2XXV0	Specify:			Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show than "natural", or Item rast be redified at	edt	15. Decedent's Education	Tor Dates.	16a. Deced	ent's Usi	al Occupa	tion		16h Ki	nd of Business	White
212	within 72 ho iene. rthan "natui ire Medical	plet	(Specify only highest grade compl	eted) ege (1-4or 5+)	(Give I	kind of w	ork done d use retired)	uring most of w	orking		01 000111000	, maddily
21	70 70 10	Completed	Elementary/Secondary (0-12) Coll	ege (1-401 3+)		Wea	aver			Rib	on Man	ufacturer
pu	m - 0 8	Be (	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle,	Maiden	Sumame)	
yla		ပ	Edwin Bussard					Alice	K. Cear			
Maryland	N 60 50 50		19a. Informant's Name/Relationship (Type, Prin						Rural Route Numbe			Zip Code)
	s 1 and 3 if Health item 27 other tr		Eugene P. Shank - Hus 20a. Method of Disposition		205 L	James	stown	Dr. Fa	lling Wat			5419
Baltimore,	of of		1 XBurial 2 ☐ Cremation 3 ☐ Removal	HUIII State	ace of Dispos emetery, crem			I .			cation - City or	
臣	Department Department mportant: any injury once.		* 4 □ Donation 5 □ Other (Specify)  21. Signatur → First Service Access 6	Gre							liamspo	rt,Maryland
Ba	permit. Departm Importa any inju		Motor M.		<u>ئے ۔</u>	) Sboi	ne F	ineral	Home, P.A	١.		04705
			23a. Part1. Enter the disease, or complications	that caused the death	. Do not ente	or the mo	de of dying	ococnea , such as cardi	gue ST. W ac or respiratory ar	rest,	amspor	t,MD 21795 Approximate
	Physician		shock, A heart failure. List only one cause Immediate Cause (Final	on each line.	1 -	-11	\	1 . 1	•			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Le to (or as a consequ	ence of):	TVA	ARC	JOH .				1 day
l.	Examiner		Constallation and the constallation	COMPAR	y 1	tite	1-7	Di3er	4Se_			ľ
	п #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ue to (or as a consequ	ence of):		t					
	and and trans	Examiner	that initiated events c.									
50,	ate be executed hysician and the burial-transit	ũ	pesulting in death, cast	ue to (or as a consequ	ence of):							
8760,	# > #	edlcal	d									
9 X	death certifica attending pt of for use as ti	/Me	IF FEMALE: 23c. If ye	s, outcome of pregnan	nev							
Вох	atten atten	Physician/M	in the past 12 months?	Live birth 2 ☐ Fetal Pregnant at time of de	death 3 □	Ectopic p Other (s	regnancy			2	3d. Date of del Month	overy Day Year
o.	the che	ıysi		Unknown		0.107 (0)						
<u>ر</u>	The law requires that te has been signed by bage 2 should be deta	by PI	Part II. Dther significant conditions contributing	to death but not resul	Iting in the und	derlying	cause give	n in Part J.	23e. Did to	bacco u	se contribute to	the cause of death?
ğ	w require been sig should b	ed k	LUNG CANCET						1 □ Y	es 2[	□No 3□Pr	obably 4 Unknown
Records,	e law requ has been je 2 shouli	Completed	J						24a. Was a		24b. Were au	topsy findings available
Ä		mo;							autops perfor		death?	completion of cause of
Vital	Physician: this certifica ral director, p	Be (	25. Was case referred to medical examiner?	7				26. Place of De	ath Check on or	/		74
of V	8 0 =	2	1 ☐ Yes 2 No Hospital:		ER/Outpatient	3□ D	Other	4 Nursing	Home 5 ☐ Reside	ence 6	□Other (Spec	cify)
n o	ding Ph) h. After this funeral o	on:		Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work		28d. Describe ho	ow injury	occurred	
Division	Attending r death. sctor: After by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be	Disease de laives - Address		M		es 2 □No	004 1 (0			
)i	I or Attent after deatl Director: I in by the	ertif	4 Homicide determined	Place of Injury - At hor building, etc. (Specify)	ne, rarm, stre	et, factor	у, опісе		City or Town	n, State)	i Number or Hi	ral Route Number,
	Hospital 24 hours a Funeral I stely filled	C	29a. Certifier 1 Certifying Physicien: 1	o the best of my know	vledge death	ОССШТВО	at the time	date and place	e and due to the c	ause/s)	and manner as	stated
	e Ho: 24 h e Fur letely	ledical	Z Medical Examiner: Of	the basis of examination manner stated.	on and/or inve	estigation	, in my opi	nion, death occ	urred at the time, d	ate and	place, and due	to the cause(s)
	To the Hospital or Atten Within 24 hours after deat To the Funeral Director: completely filled in by the	Me	29b. Signature and tille of certifier			29	c. License	number	2		signed (Montl	
	12		Allen				D 2	7940	i	M	azh	29 2004
	4		30. Name and address of person who or mpleted	cause of death (Item :	23а) (Туре, Р	rint)	0			, ,,		(
			D. Hatleberry	11/16	Medi	cest	lan	pus	Rd.	142	4. M.	29 2004
8	Sta Registr	-	31. Date filed (Month Park 30 2004	32. Registrar's Signatu	d.	and the	9	•			,	

			1 - For State Registrar	State of Mar	yland / Dep <i>Ce</i>	artment of rtificate of	Health and Death		iene 200	4 12843
	Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of Death Month	h Day Yea	3. Time of Death
	/Medi		Jack Preston SISK					March	29 200	
	Examir	ner	4a. Fecility Name (If not institution, give s Washington County				or Location of Dea	ath	4c. County of De	
3	Funeral		5. Social Security Number 6. Sex	7. Age (	In yrs. last birthday)	If Under 1 Year	erstown r   If Under 24 Hr	s. 8. Date of Birth	Washir	
	Director		217-12-2766	M 2□F 81		Months Days	s Hours Mir	8. Date of Birth (Month, Dey, Feb. 22,	1923 Ma	irthplace (State or Foreign Country) aryland
	p .		Usuel Residence of Decedent  10a. State 10b. County		0c. City, Town or Lo					
	faryla hov	5	Maryland Washing		Hagerst					10d. Inside City Limits 1 ☐ Yes 2 No
	the A	rect	10e. Street and Number	COII	nagersco	10f. Zip Code		10	ng. Citizen of What (	
	h with	0	10920 Lincoln Aven	ue		2174	40		USA	,
	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show ha Madical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of	Hispanic Origin? (	Specify Yes or No- rto Rican, etc.)	14. Race - An Black, Wh	nerican Indian,
36	s after , or it	by Fu	1 Never Married 2 Married	1 X Yes 2 □ No		1 ☐ Yes 2 🔀 No		no moun, otc.,		white
21215-0036	hour: tural	ed b	3 X Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates: V		dent's Usual Occu	postion		6b. Kind of Busines	
15	nin 72 n "na Medic	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retin	e during most of wo	orking	ob. Killa of Basilles	Sindustry
212	filed withi Hygiene. other then	Completed	8	0	Co	rrection	nal offic	er	state	
pu	be filed ital Hygi od other	Be	17. Father's Name (First, Middle, Last)  Albert J. Sisk					me (First, Middle, M		
Maryland	2 should be and Mental ie marked o	10		0.1.0				Matthews		
Z	DE MA		19a. Informant's Name/Relationship (Ty) Bryweag P. Harne -					lura <i>l R</i> oute Number, Hagerstown		
ē,	permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tra once.	-	20a. Method of Disposition		20b. Place of Dispo	sition (Name of		The second secon	Oc. Location - City of	
E C	Pages nent of lint: If its		1 Burial 2 □ Cremation 3 □ R  1 □ Donation 5 □ Other (Specify)	emoval from State	Manor Ce	natory`or other pla emetery	· 1	1/04 T	ilghmanto	n, Maryland
Baltimore,	permit. Departrimporta		21. Signature of Funeral Service License	200	. 2	. Name and Addr	ess of Facility		FUNERAL	
<u> </u>	89 2 2 9		2000 1	Malan	uer !			., Hagers		21740
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  Due to (or	on equence of):	heck miles	ing, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death 2 in the Approximate Interval Between Onset In
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a d	consequence of):	al Ob.	struct	in		2 wells
9	tificat ng phy as th									
.O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 2 (4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnance Other (specify)	Э		23d. Date of de Month	elivery Day Year
Records, P.	w requires that been signed I should be det	by	Part II. Other significant conditions con	tributing to grath but full facilities for the full full full full full full full ful	ot resulting in the u	nderlying cause gr	ven in Part I.	23e. Did toba	-4	to the cause of death? Probably 4 Unknown
ပ္ပ	e iaw requ has been ge 2 should	Completed	ma	helee	milli	4		24a. Was an		utopsy findings available
Ä	ysician: The is certificate hadirector, page	Com	He	merter	usion'			autopsy perform 1 Yes 2	ed? death?	
Vital	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					ath (Check only one		
of	유 수 후	2	1 Yes 2 No	28a. Date of Injury	2 ER/Outpatien	1 3 DON		Home 5 Residen		ecify)
on	fter	tlon	Natural 5 Pending	(Month, Day Y	ear) 28b. Time of Injury	28c. Inju Wo	ryat rk? ]Yes 2 ∐No	28d. Describe how	/ Injury occurred	
Division	of or Attending after death. I Director: After d in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, str Specify)			28f. Location (Stre City or Town,	eet and Number or R State)	lural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	one) 2 Medical Examin	ician: To the best of n er: On the basis of ex and manner stated	amination and/or inv 1.	estigation, in my	opinion, death occu	urred at the time, dat	e and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens	se number	290	1. Date signed (Mon	th. Day, Year)
	1×1		, logi	1		<u> </u>	74776		Manch 2	7,2007
	54		30. Name and address of person who con	K MD	h (Item 23a) (Type, 20 3/1	Cappa	ns Rd	Boonsbo	20 MB	21713
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 3 0 20	32. Régistrar's	J. A.	antis				

		1 - For Amend Item Registrar  1. Decedent's Name (First, Middle, I					0, 0			2. Date of De	ath			Time of Death
Physici /Medio		GEO	RGE 1	MCCLEL:	LEN	ST	APLI	ES		Month 41	Day 1	200		1105
Examir	er	4a. Fecility Name (If not institution, g 1 Central Pa		ber)		4b. City, T						County of D		
				'. Age (In yrs. la:	st hinthday)	If Under 1		Pin If Under 2		P. Date of Bird		Worce		
Funeral Director		405-20-4428	1 <b>⊠</b> M 2□F		9 Yrs.		Days	Hours	Min.	8. Date of Bird (Month, Da 4-11	, Year)	9.	Country)	(State or Foreig
2		Usual Residence of Decedent												
Marylar f show	jo	Md. Worce	ster		Town or Loc ean F									iside City Limit Maryes 2 □ N
3a or 28a	<b>Funeral Director</b>	10e. Street and Number 1 Central Pa	rk West			10f. Zip (	Code 1811	1				izen of What	Country?	
n /2 nours after death with the Maryland "naturel", or Items 23a or 28a-f show siteal Examit or mast be netitied at	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Ford	lent Ever in U.S. ces? 2 No es: WWI:	lf.	Vas Decede Yes, specif		panic Orig , Mexican, Specify:	in? (Spe Puerto f	cify Yes or No Rican, etc.)		14. Race - A Black, W Specify:	merican Ind /hite, etc. Whit	,
	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		4or 5+)	16a. Deced (Give) life. D	ent's Usual kind of work OO NOT use	Occupati done du retired)	ion ring most	of workir	ng	16b. Ki	ind of Busine	ss/Industry	
Hygien Hygien ther th	Соп		41			Engi						Chemi	cal	
e d a g	To Be	17. Father's Name (First, Middle, Las George McCle	-	aples			1			(First, Middle, armich		Sumame)		
s 1 and 2 should f Health and Men ftem 27 le marke other treumatic	·	19a. Informant's Name/Relationship Margaret K.								Route Numbe	-			•
rages 1 a nent of Hea int: If Item iry or othe		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5 Other (Spec		tate cen	ce of Dispos netery, crem Lisbu	atory or oth	er place)		D:	ate - 0 4		cation - City		
permit. Pages 1 and 2: Department of Health at Important: If Item 27 le any injury or other tree once.		21. Signature of Funeral Service Lic	•	Su	22.	. Name and	Address	of Facility	, –	Home			-	
		23a. Part1. Enter the disease, or co	mplications that cau	used the death.										oximate val Between
hysician /Medical		shock, or heart failure. List online Immediate Cause (Final disease or condition resulting in death)	a.	r as a conseque	CON	cen								val Between et and Death
sale be executed  bhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause; Useass or injury that initiated events resulting in death) Last	С.	r as a conseque									ISK 7	0 02001
rite raw requires first fire beant certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 Fetal dent at time of deal	eath 3 🗆	Ectopic preç Other <i>(spec</i>					2	23d. Date of o	delivery Day	Year
w requires inta been signed t should be det	by	Part II. Other significant conditions	contributing to dea	th but not resulti	ing in the un	derlying cau	ise given	in Part I.		4	bacco u es 2 d	se contribute Mo 3□		se of death?
	Completed							· - · .		24a. Was a autop: perfor	sy	24b. Were prior to death	o completio	dings available of of cause of
yarcian: III is certificate director, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only or	ie)			
	on: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 ☐ Ing 28a. Date of (Month,		Outpatient  Bb. Time of Injury		Other: c. Injury at Work?	4   Nurs		e 5 Residente de R			pecify)	
of Attending First states death.  I Director: After this d in by the funeral d	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	f Injury - At home	e, farm, stre	M et, factory, o	-	s 2 □ N		Bf. Location (S City or Tow	reet and n, State)	d Number or	Rural Route	e Number,
rs a	Medical Ce	(Check only 2 Medical Exa	Physicien: To the baminer: On the bas	is of examination	edge, death	occurred at	the time,	date and	place, ar	nd due to the c	ause(s) ate and	and manner place, and d	as stated.	luse(s)
Funel Funel Funel	77	one)	and manne	r stated.										
ithin 24 hour the property of the Funer	Me	29b. Signature and title of certifier				29c	_icense n	umber				SIGNAG (MA)	nth. Dav V	ear)
within 54 hours and within 54 hours and within 54 hours and the death completely filled in by the	Mec	29b. Signature and title of certifier	0.0	,			License n	redmur	5		90. Dale	signed (Mo	nth, Day, Y	ear)

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of rtificate of		-	giene Reg. No. 2	004	12845
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last     BERNICE     Bernica	HOLLOWA			or Location of Deatl	2. Date of De Month 03	3 1 4c. Cou	Year 0 4	3. Time of Death 5:05a. M
	Funeral Director		Civista Medic 5. Social Security Number 6. S 577-90-4731		r (In yrs. last birthday, 81 Yrs.	LaP1	If Under 24 Hrs.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthpl County	lece (State or Foreign try)
		ctor	Usual Residence of Decedent  10a. State 10b. County  MD CHARL		10c. City, Town or L			, 10	1722		Od. Inside City Limits 1 XYes 2 ☐ No
36	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show the Medical Exprinter must be redified at	by Funeral Director	10e. Street and Number 2988 HICKORY  11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give	ver in U.S. 13.		601 Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No o Rican, etc.)		S . A . lace - America lack, White, e	an Indian,
21215-0036		Completed b	3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12) 6 t h	de completed) College (1-4or 5+	(Give		a during most of wored) MAKER			Business/Ind	
Maryland		To Be	17. Father's Name (First, Middle, Last) GEORGE	GAI	NES		18. Mother's Nar	1	BRA	DFORD	
	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		19a. Informant's Name/Relationship ( TANYA M. GUNN  20a. Method of Disposition  1X Burial 2 Cremation 3 C	- DAUGHTE	R 2988	HICKOI osition (Name of matory or other pla	ace)	Y DR.,	WALD	ORF,	MD 20601 wn, State
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O. Box 68	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify)	ey			Date of deliver	ry Day Year
٩	quires that n signed b		Part II. Other significant conditions of Herica 2000	ontributing to death but	t not resulting in the u	inderlying cause g	ven in Part I.		obacco use co Yes 2 □ No		e cause of death?
Vital Records,	icisn: The law requires that the certificate has been signed by the rector, page 2 should be detache	e Completed by	Diato C  25. Was case referred to medical	Artio H	yopu to	Ivale	26. Place of Dea	1 ☐ Yes	rmed? 2XNo	prior to con death?	osy findings available apletion of cause of
of	ling Phys ). After this (uneral di	ToB	examiner?  1 Yes 2 0  27. Manper of Death Natural 5 Pending 2   Accident investigation	Hospital: 1 Impation 28a. Date of Injury (Month, Day	28b. Time o	of 28c. Inju	her: 4 Nursing H	ome 5 Resident Reside	dence 6 🗆 C		)
Division	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, st (Specify)	reet, factory, office		28f. Location (: City or Tou		mber or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	(Check only 2 Medical Examone)	rysician: To the best of niner: On the basis of and manner state	examination and/or in	vestigation, in my	opinion, death occu	, and due to the rred at the time,	date and place	e, and due to	the cause(s)
	3	2	29b. Signature and title of certifier  30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	D-00	26262		29d. Date sign	ned (Month, E	Day, Year)
	St. Regist	ate rar	Samuel J. Klei 31. Date filed (Month, Day, Year)	145	11711 Li		n Rd Fo	rt Wash	ningto	n, MD	20744

DHMH 17 Rev 1/2001

JOSHUA J. STONE 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene

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**Physician** /Medical **Examiner** 

**Funeral** Director

illed within 72 hours after death with the Maryland 28a-f show other traumatic event, the Mudical Examiner must be notified at ō or Itams 23a "naturs!" other then

Realtimore, Maryland 21215-0036

Physician /Medical **Examiner** 

Physician: The law requires that the death certificate be executed burial-transit and physician use as the for signed by the a page 2 should has funeral director, After or Attanding To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A the

Division of Vital Records, P.O. Box 68760,

5. Social Security Number 7. Age (In yrs. last birthday) 1**⊠** M 2□ F 214-23-5405 15 Usual Residence of Decedent 10c. City, Town or Location 10b. County Director Maryland Prince George's Beltsville 10e. Street and Number 10f. Zip Code 4110 Howard Road 20705 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 11. Marital Status 1☑ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) Student Note: Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked other property or other traumatic event 17. Father's Name (First, Middle, Last) Joseph Stone 19a. Informant's Name/Relationship (Type, Print) Wilhelmina Stone (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Removal from State 2 Cremation 3 Removal from State \* 4 ☐Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 21. Signature of Funeral Service Licensee aunine Immediate Cause (Final disease or condition resulting in death) Hanging Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Lines of outsigning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 1X Yes 2 □ No 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Fund 3-31-04 Foud 6-33 AM 1 ☐ Yes 2 🗖 No 2 Accident 6 Could not be 3 X Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number O.C.M.E ん m. 0

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH 31, 2004 Joshua Jordan Stone 0635 A M 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES 4110 HOWARD ROAD BELTSVILLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 13, 1 Birthplace (State or Foreign Country) 1988 Maryland 10d. Inside City Limits 1 Nes 2 No 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Government 18. Mother's Name (First, Middle, Maiden Surname) Wilhelmina Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4110 Howard Road, Beltsville, MD 20705-2800 20c. Location - City or Town, State 4/6/2004 Silver Spring, MD 22. Name and Address of FacilityLatimore Funeral Services, P.A. 6906 Kent Town Drive, Landover, MD 20785 23a. Part 1. Enter the disease, or pollulations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 💢 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2 □ No performed? 1 X Yes 2 🗆 No

Other: 4 Nursing Home 5 Residence Other (Specify) AT SCENE 28d. Describe how injury occurred

Subject harged brimself

28f. Location (Street and Number or Rural Route Number, City or Town, State) 4110 Howard Rd Beltsville mD

> 29d. Date signed (Month, Day, Year) MARCH 31, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) 32. Degistrar's Signature 05 2004

m.D

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DHMH 17 Rev 1/2001

State

Registrar

				State of Maryla	and / Depa	artment c		-		e 200	4 12847
			1. Decedent's Name (First, Middle, Last)					2. Date of Month		ay Year	3. Time of Death
	Physici /Medi		PRECIOUS L.	SHAW				3	2	9 04	05:36A <sup>M</sup>
	Examir		4a. Fecility Name (If not institution, give si	treet and number)		4b. City, Tov	wn, or Location o	f Death		c. County of Dee	
1			SOUTHERN MARYL 5. Social Security Number 6. Sex	AND HOSPI	TAL.	Clin		24 Hrs. 8. Date of		Prince	
	Funeral		1.	M XIF 64	rs. last birthday) Yrs.		ays Hours	Min. (Month,	Day, Yea		thplace (State or Foreign ountry)
	Director		250 60 4610 Usuel Residence of Decedent	0 4					11	39 BOU	th Carolin
	yland		10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
10	Mar Hind	to	Md. Prince G	eorge F	orestv	ille					1 ☐ Yes 2 🕅 No
36	th the	lre	10e. Street and Number			10f. Zip Co			1 -	itizen of What C	ountry?
1	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neturel, or Items 23a or 28a-1 ehow other traumatic event, the Madical Examinar mast be notified at	Funeral Director	3127 Dynasty Dr			207					
35	tems	nue	11. Marital Status	<ol><li>Was Decedent Ever in Armed Forces?</li></ol>	n U.S. 13.	Was Decedent f Yes, specify	t of Hispanic Orig Cuban, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Am Black, Whi	
38	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀	No Specify:			Specify: B	lack
、スタ. <i>34</i> Maryland 21215-0036	hour turel	pe pe	15. Decedent's Educ		16a, Dece	dent's Usual O	ccupation		16b.	Kind of Business	Vindustry
<u>+</u>	in 72	Completed	(Specify only highest grade	completed)	(Give	kind of work a DO NOT use r	done during most etired)	of working			
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S D	Hyg other	Be C	17. Father's Name (First, Middle, Last)					r's Name (First, Mic	ldle, Maide	en Sumame)	
ar an	Mental	ToB	Johnnie Miles				E11		ckso		
of ST	S should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	1 8	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	ng Address (Si	treet and Numbe	r or Rural Route Nu 1ve	mber, City	or Town, State,	Zip Code)
	fealth and 2 in 27 is		Della Shaw, Dau	gther				ryland Date			
3 Baltimore,	ges 1 and of the minimum or other	1 1	20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Re	1	b. Place of Dispo cemetery, crei	sition (Name of matory or other	of r place)	4/2/04			Town, State
Ĕ	Pege ment o tant: If		`4 □Donation 5 □ Other (Specify)	1	ort Lir	coln	i		DI	entwood	1,1141 / 14114
<u>a</u>	Departmen Departmen Important: eny injury		21. Signature Funeral Service License		25	Name and A	ddress of Facility	S FUNER	AT. H	OME	20001
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			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the die cause on each line.	leath. Do not ent	er the mode o	f dying, such as	cardiac or respirator	ry arrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):						
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750	te be executed ysicien and le burial-transit	calE									
20,789	tificate ng phys as the	gge									
	eath certificate attending phy:	N N	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre		3-				23d. Date of de	elivery
E C	death a atte	clai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time		⊒Ectopic pregr ⊒ Other <i>(speci</i> i			_	Month	Day Year
77	t the d	hys	9 Unknown	9□ Unknown							
1 2	- 60	Completed by Physician/Medi	Part II. Other significant conditions con	-	resulting in the u	nderlying caus	se given in Part I.	23e. E	oid tobacco	use contribute t	to the cause of death?
ģ	w require been sig should b	edi	BREAST CAN	ICER				1	Yes	2 □ No 3 □ P	robably 4 Unknown
S	aw re as be	plet	DISSEMINATE	D METAST	TASIS			а	Vas an utopsy	/ prior to	utopsy findings available completion of cause of
ä	Physician: The lav this certificate has al director, page 2	Eo						P	erformed?	death?	
ita i	ian: rtifica ctor, I	Be	25. Was case referred to medical examiner?				26. Place	of Death (Check or	nly one)		
35	hysic nis ce I dire	2	1 Yes 2 No		2 FVOutpatier			rsing Home 5 🗆 F			ecity)
How of Vital Records.	ding Pl h. After ti funera	ino	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o		Injury at Work?		ibe how in	jury occurred	
150	ttendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2 1				10
$\bigcirc$	lor Att after d Direct	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, sti pecify)	reet, factory, o	ffice		Town, Sta		lural Route Number,
<b>'</b> -	ospital of hours at unerel E		20 Cadifier 1 Tadificing Phys	sician: To the best of my	keaudadaa daat	h accurred at t	the time date an	d place, and due to	the cause	(e) and manner a	e stated
	Hospital 24 hours Funerel etely filled	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	ner: On the basis of exame and manner stated.	nination and/or in	vestigation, in	my opinion, dea	th occurred at the ti	me, date a	nd place, and du	e to the cause(s)
	To the Hospital or Attention within 24 hours after deatl to the Funerel Director:	Mec	29h Signaturà and title of cepitier	and mailton stated.		29c. L	cense number		29d. D	Date signed (Mon	th. Day, Year)
	- 3 - 3		+ Toopie			D	4032	ĺ	MA	RCH 2	1,2004
	(5)		30. Name and address of person who co	empleted cause of death (	(Item 23a) (Type.	Print)					
	0	i		, MID. , 75		RATTS	ROAD, C	CLINTON	MAR	CURALPS	20735
	S	tate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature						
	Regis	trar	ΔPR 0 5 2004	Hearing &	4 Span	(1)					

			For Stete	State of	Marylan		artment of	Health and	Mental H		2001	12818
			Registrer  1. Decedent's Name (First, Middle, La	ist)		00,	tineate of	Death	2. Date of D		2004	3. Time of Death
	Physicia		Eleanor M. Sabado	•					Month April	7 . 2	y Year 2004	4:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give		oer)		4b. City, Town,	or Location of Oea			County of Death	4.00 A
	LAGITIII	C,	Suburban Hospital	1			Bethesd	a		M	ontgomery	V
	Funeral		5. Social Security Number 6.5	Sex 7.	. Age (In yrs.		If Under 1 Yea Months Days			lirth Day, Year	9. Birthp	place (State or Foreign
	Director		207-26-0450	1□M 2XIF	71	Yrs.			Feb.	16, 1	933 Penn	sylvania
	and	}	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	IOd. Inside City Limits
	daryli f sho	20.	Maryland Montgome	3417	Poo	kville						1∏ Yes 2 □ No
	the 28a-	Director	Maryland   Montgome	Ly	Roc	KVIIIE	10f. Zip Code	1		10g. Ci	tizen of What Cour	ntry?
	h with		12914 Twinbrook I	Parkwav			20851			Uni	ted State	9 4
	items 2	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.	.S. 13.		Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or N		14. Race - Americ Black, White,	can Indian,
9	ours after death with the Marylar ral', or Items 23a or 28a-f show Examiner must be notified at		1 Never Married 2 Married	1 Tes 2	<b>∑</b> No		I□Yes 2⊠ N					nite
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	be filed within tal Hygiene. d other than event, the M.	BeC	17. Father's Name (First, Middle, Las.	1)				18. Mother's Na	me (First, Middi	le, Maider	Sumame)	
/lar	uld by Wents urked	ToE	Charles Shamis					Anna Lo	renz			
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	os I and 2 should be filed within of Health and Mental Hygiene. If Item 27 is marked other than it other traumatic event, the Me.		Stephen J. Sabado	os/ Son	20h E		4 Twinb: sition (Name of	ook Park	way, Roo			land 20851
0.0	Ses 1		20a. Method of Disposition 1   ↑ Burial 2 □ Cremation 3 [	Removal from St	ate Out	emetery, crer	The Uni	verse Apr	il 13,		ocation City or To Wegian To	
مم Baltimore,	t. Partmen		*4 ☐ Donation 5 ☐ Other (Special Service **Service	400	Cemete	rv	20	04	Penn	asvlvania		
H A Bal	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra once.		May 17		M00689	Be	thesda-(	Chevy Cha	se. 755	7 Wis	sconsin A	neral Home/ venue
			23a. Part / Enjer the disease, or con should or heart failure. List only	plications that cau	used the deat th line.	h. Do not ent	er the mode of dy	ring, such as cardia	c or respiratory	arrest,		Approximate Interval Between
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7/2	/Medical Examiner		resulting in death)	Due to (or	ras a conseq	uence of):						
40/2	_xammor	-	Sequentially list conditions,	b. Due to (or	r as a conseq	neuce of):						
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nox ox	death certificate be executed e attending physician and od for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		lEctopic pregnan	су			23d. Date of delive	
2. B.	ne dea the att	sici	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnar 9□Unknow	nt at time of d		Other (specify)				Month	Day Year
P. 6	by by		Part II. Other significant conditions	contributing to dea	th hut not res	ulting in the u	nderlying cause o	uven in Part I	23e Oid	tobacco	use contribute to the	ne cause of death?
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700	v requ	lete							24a. Wa	is an	24h Were auto	psy findings available
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Vital	iclan: Th certificate rector, pag	e C	25. Was case referred to medical	1				26 Place of De	1 ☐ Yes eath (Check only	2 <b>X</b> No	1 ☐ Yes	2 No
-	Physiclan: r this certifica ral director, i	0 8	examiner? 1 □ Yes 2 ☑ No	Hospital:	patient 2	ER/Outpatier	t 3 DOA	thon			6 □Other (Specif	(v)
2 را	ding Physician: The n. n. After this certificate h. funeral director, page	T iu	27. Manner of Death	28a. Date of (Month,	Injury Day Year)	28b. Time of			28d. Oescribe			
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ব <u>ই</u>	or Atterder de l'recton	Certification;	3 Suicide 6 Could not l 4 Homicide determined	286. Place o	f Injury - At he g, etc. (Specif	ome, farm, str	eet, factory, office	9		(Street all own, State	nd Number or Rura e)	I Route Number,
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	To the Hospital or Attentwithin 24 hours after deati To the Funeral Director: completely filled in by the	edical	29a. Certifier 1  (Check only 2  Medical Exa one)	miner: On the bas and manne	is of examina	tion and/or in	restigation, in my	time, date and plac opinion, death occ	urred at the time	e cause(s e, date an	d place, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	010	2~	M.D	29c. Lice	nse number		29d. Da	te signed (Month,	Day, Year)
	20		•	1. Cell	30-	(	D365	52		Apri	1 7, 2004	4
			30. Name and address of person who	,	,							
			Pankaj Talwar, 50	50 D	lmonsto gistrar's Signa		e #401,	Rockvill	e, Mary	land	20852-12	244
	Sta Registr		APR 0 9 20	104	per a	19	spork	2				

				State of Ma		d / Depa	artment	of H	leaith a			giene				
		_	For State Registrar			Cei	rtificate	of L	Death				200		128	149
	Physicia	an	Decedent's Name (First, Middle, Las	")							2. Date of D Month		004 <sup>Ye</sup>		. Time of I	
1	/Medic	al	Robert A. Salazar	-Area and average			4b Cib. T		Location of		pril 4		Ounty of E	) o o th	6:55	P ™
	Examin	er	4a. Facility Name (If not institution, give							or Death						
	Funeral		3306 Jones Bridge 5. Social Security Number 6. Se		e (In yrs. la	ast birthday)	Chevy If Under	1 Year	If Under:	24 Hrs.	B. Date of Bi	-41-	ntgom 9.	ery Birthplace Country)	(State or	r Foreign
	Director		266-36-5616	M 2□F	73	Yrs.	Months	Days	Hours	Min.	Month, D	193	0 A3	Couintry) Labam	a	
	pu ,	Ì	Usual Residence of Decedent  10a. State 10b. County		100 Cibe	. Town or Lo	parties							104	Inside Cit	ar Limita
	shov	5			,										1 Yes	
	28a-f	ect	Maryland   Montgome:	ry	Cne	evy Ch	10f. Zip (	Code				10g. Cit	izen of What	t Country?	,	
	with 3a or	Funerai Director	3306 Jones Bridge	Road			208				į	_	ed St			
	death ms 2	nera	11. Marital Status	12. Was Decedent I	Ever in U.S	S. 13.	Was Decede	ent of Hi	ispanic Ori	gin? (Spec	ify Yes or N ican, etc.)		14. Race - A			
9	or Its		1 Never Married 2 Married	1X Yes 2 □ N			1 Yes 2		Specify:	, 1 00110 11	iouri, otc.)		Specify:	-		
8	within 72 hours after death with the Maryland ene. than "natural", or Itams 23s or 28s-f show the Modical Expoliner must be notified at	d by	3 ₩ Widowed 4 Divorced	Year or Dates:N	orea	16a Daga	dent's Usual	Ossus	ation			165 K				
15-	in 72 "nat	ojete	15. Decedent's Ed (Specify only highest grad	de completed)		(Give	kind of work DO NOT use	k done d e retired	during mosi	t of working	9	100. K	ind of Busine	ass/indust	ry	
212	with giene. r thar	Completed	Elementary/Secondary (0·12)	College (1-4or 5	i+)	Depart						Fed	leral (	Gover	nmen	ıt
br	e filec al Hyg otha vant,	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name (	(First, Middle	, Maiden	Sumame)			
ylaı	ould b Menti arkad atic e	70	King Alphonse Sala								able I					
Jar	12 short and rism		19a. Informant's Name/Relationship (7		_								or Town, Stat		•	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It a Medical Experimer must be notified at once.		Gregory J. Schwar	tz/Son-in-	20b. PI	ace of Dispo	sition (Name	e of					ncton cation - City			
nor	ages ont of t: # it		1 ☐ Burial 2 【ACremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify			metery crei tgomer matori	mataniae atl	har alaa	(e)   I	April 2004						
Ħ	artme ortan Injur		21. Signature of Funeral Service Licen		Crei	matori 22	.um , 11	nc. Addres	s of Facilit			Pump	iesda, hrev l	Mary Funer	al H	ome/
Ba	Dep Per Per Per Per Per Per Per Per Per Per		15/2	54	M01	346 Be	thesd	a-Ch a, N	nevy ( Maryla	Chase and 2	0814	755	hrey I 7 Wis	consi	ln Av	enue
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused										Ap	proximate erval Betw	,
Į	Pnysician		Immediate Cause (Final disease or condition	Acute My										On	set and D	eath
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):										
	LAGIMINE	_	Sequentially list conditions,	b. Coronary Due to for as			urger	У						4		
	uted Insit	Examiner	Sequentially list conditions, it any leading to in readile cause. Enter Underlying Cause (Disease or injury that initiated events	Atherosc			art D	isea	ise							
),	sician and burial-transit	Еха	resulting in death) Last	Due to (or as												
1760,	= > =	cai		<sub>d.</sub> Hyperten	sion											
68 3	The law requires that the death certifica Ite has been signed by the attending ph bage 2 should be detached for use as th	Med	IF FEMALE:													
Вох	ath ce	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal	death 3[	Ectopic pre					1	23d. Date of Month	delivery Day	, Y	ear
o.	that the de ad by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	ante or de	atin 5	Other (spe	спу)								
Ω.	that had by deta	by Ph	Part II. Other significant conditions co	ontributing to death bi	ut not resu	ılting in the u	nderlying ca	use give	en in Part I.		23e. Did	tobacco u	ise contribut	e to the ca	ause of de	eath?
rds	w raquires been sign should be										1 📉	Yes 2	□No 3□	Probably	4 🗇 U	nknown
Records,	e law raqu has been je 2 shoul	Completed									24a. Was		24b. Were	autopsy to comple		
- B		Com									perf	ormed? 2 No	death	h? Yes 2		<b>430 0</b> 1
Vital	Physician: This certificated director, p	Be (	25. Was case referred to medical examiner?	Hanrital.				Oth .		of Death	Check only	one)				
of	ys dis	10	1 X Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie 28a. Date of Injur		ER/Outpatier		A Othe Bc. Injury	40140		e 5 🔀 Res		6 Other (S	Specity)		
on	ding Ph h. After th funeral	tion	1 XNatural 5 Pending 2 Accident investigation	(Month, Da)	Year)	Injury	M	Work	ر؟ Yes 2.⊟I		. DOSCINDO	now injui	y occurred			
Division	or Attanding after death. Diractor: After in by the fune	ifica	3 Suicide 6 Could not be	28e. Place of Inju	ury - At ho	me, farm, str	eet, factory,	office		28			d Number o	r Rural Ro	ute Numb	oer,
Ö	s afte al Dira	Certification:	4  Homicide determined	building, etc	с. (Зреспу	7				W	City or To	wn, State	)			
	To the Hospital or At within 24 hours after of To the Funaral Dirac completely filled in by	edicai (	29a. Certifier 1X Certifying Phyone) 2 Medical Exam	sician: To the best of the basis of	of my know examinat	wledge, deat ion and/or in	n occurred a	it the tim	ne, date an pinion, dea	d place, an	d due to the	cause(s) date and	and manne	r as stated due to the	d. cause(s)	
	To the within 2 To the complet	Med	29b. Signature and little of cepting	and manner sta	1.60.		29c.	License	number			29d. Dat	e signed (M	onth, Day,	Year)	
1	511		1/1/1/	11	1/		DO	051	527			Apr	il 6,	2004	+	
! ~	J 11		30. Name and address of person in o	completed cause of d	eath (Item	23a) (Type,	Print)									
			Edwin C. Chapman,				oad, l	N.E.	#200	), Was	shingt	on,	DC 200	002		
	Sta Registr		APR 0 7 20	32. Registra	ar's Signat	ture 4	la	uks								
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			1 - For State Registras/MEND#26per/MD4	State of Maryla		artment of F ertificate of			200	4 12850
			Registrar/MFND#26perMD4  1. Decedent's Name (First, Middle, La.			Tillicate of	Dealii	2. Date of Death	g. 140.	3. Time of Death
	Physici	an	1, Decedent's Name (First, Middle, Las	4 CANA	75			Month 1	Day Yee	
	/Medic		4a. Fecility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of Deat	h	4c. County of De	eeth
	Examin	er	Howard County Gene			Columb			Howa	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yr	s. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplece (State or Foreign Country)
	Director			XM 2 F	57 Yrs.	Months Days	110010	Dec.11,		ndia
	and		Usuel Residence of Decedent  10a. State 10b. County	10c. (	City, Town or L	ocation				10d. Inside City Limits
	f sho	ō	Maryland Howard		Colum	bia				1 ☐ Yes 21 No
	r 28a	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or tems 23a or 28a-f show thit, the Medical Examiner must be natified at	al D	9220 Broken Timbe	er Way		21	045		United S	States
	deat	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Ar Black, W	nerican Indian,
98	or the	y Fu	1 ☐ Never Married 2 🂢 Married	1 ☐ Yes 2 ☐ No If Yes, Give X		1 ☐ Yes 2 ☑ No	Specify:		Specify:	Asian
g	hours fural',	d be	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a Deed		antion		l6b. Kind of Busines	
5	in 72	olete	(Specify only highest gra	de completed)	(Give	edent's Usual Occup e kind of work done DO NOT use retired elf emplo	during most of word)	rking		
212	l with jiene. r than	E O	Elementary/Secondary (0-12)	College (1-4or 5+) 1-4	S	elt embro	yed		Real Est	ate
Maryland 21215-0036	al Hyg	3e C	17. Father's Name (First, Middle, Last) Khalifa Saeed Has	ccan				ne (First, Middle, M	laiden Sumame)	
ylar	Menta Menta arked arice	To	Maiita baeed nas	san			Qumar (			
Mar	2 sho		19a. Informant's Name/Relationship ( Farwa Sayed -wif	** '		ing Addrass (Street				
e, r	1 and 1ealth 1m 27 ther t		20a. Method of Disposition			Broken T	Timer way	The second secon	a, Maryla Oc. Location - City	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at an once.		1 Qurial 2 Cremation 3	Removal from State	cemetery, cre	ional Mem	。Park 4/1		Laurel, M	
Ē	artme ortani injury		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer	"						-
Ba	Per Per Per Per Per Per Per Per Per Per		David UB	walt	l	Donald V. 400 Powde	Borgward r Mill Ro	t Funeral	l Home, P	.A. yland 20705
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	ath. Do not en	iter the mode of dyir	ng, such as cardiad	or respiratory arre	st,	Approximate Interval Between
ţ şa	Physician		Immediate Cause (Final disease or condition	Myn	LART	VAL T	LIEAR	CTION		Onset and Death
12	/Medical		resulting in death)	Due to (or as e cons	equence of):	16100	-10111		Ч	1,100
В	Examiner	L	Sequentially list conditions,	b						
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):					
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or as a conse	equence of):					
760,	eath certificate be executed attending physicien and for use as the burial-transit	calE		d.						
89	tificati g phy as th									
Вох	th cer endin	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		☐Ectopic pregnancy	,		23d. Date of d	
Э. П	the att	slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)	,		Month	Day Year
P.O.	that the death ed by the atte detached for	Phy	9 ☐ Unknown  Part II. Other significant conditions of	contributing to death but not re	aculting in the	adothing cause an	on in Part I	23e Did tob	acco use contribute	to the cause of dea/h?
ds,	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as th	Completed by Physician/Medi	MARFANIC.	SYNDRON	M/>	andanying datase giv	on in tall.		s 2 No 3	
Sor	v requ	lete	111110	3/10/0/200	16			24a. Was an		autopsy findings available
Re	The lav	dmo						autopsy	ed2 prior to	o completion of cause of
tai			25. Was case referred to medical			/	26 Place of Dea	1 ☐ Yes 2	Ø/No 1 □ Ye	es 2 No
<u> </u>	Physician: r this certific ral director.	To Be	exampler? 1 Yes 2 No	Hospital: 1 ☐ Inpatient -2	- desemble	DOA Oth	or	ome 5 Resider		pecify)
0 0	ng Ph fter th neral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injur Wor	y at k?	28d. Describe how	v injury occurred	
Sio	eath. or: A	catic	2 Accident investigation 3 Suicide 6 Could not b			M 1 🗆	Yes 2 □ No			
Division of Vital Records,	l or Attending I after death. Director: After in by the funer	Certification:	4 Homicide determined		home, farm, st cify)	treet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely illed in by the funeral director.		29a. Certifier 1 Certifying Ph	nysician: To the best of my k	nowledge dea	th occurred at the fir	me date and place	and due to the car	use(s) and manner	ac etated
	24 hos 24 hos 6 Fun letely	edical	(Check only 2 Medical Exer	niner: On the basis of exami and manner stated.	nation and/or in	nvestigation, in my o	ppinion, death occu	rred at the time, da	e and place, and d	ue to the cause(s)
	To the within 2 To the Complet	Me	29b. Signa , and title of certifier	1 \		29c. Licens	e number	29	d. Date signed (Mo	nth, Day, Year)
)	1		Dest of Ma	run MD		00	18949	2 - 1	childs	, 2004
	>		30. Name and address of person who	completed cause of death (It	em 23 i (Type	, Print)	tio Da	Ā	- 1	11071142
			31. Date filed (Month, Day, Year)	DD [M] 32. Registrar's Sig	NOUZ	-MONIC	HILPH	LLYC	57414	111111111111111111111111111111111111111
	Sta Registi		APR 0 8 20	04 Serena	G	Spacks				

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Am Ayon L Schectman 2004 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2□F Director 183-16-1164 Sept 22, 1922 Pennsylvania Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Haaith and Mantal Hygiene.

ant: If Item 27 is marked other than "naturel; or items 23s or 28s-f show ury or other traumatic event, if a Medical Examiner must be notified at 10a. Stete 10b. County 10c. City. Town or Locetion 10d. Inside City Limits I is marked other than "naturel", or items 23s or 28s-f shor traumstic event, the Medical Examiner must be notified at 1☐Yes 2☐No Funeral Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15101 Interlachen Drive, #426 20906 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 ◯ Widowed 4 □ Divorced Year or Dates white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Federal Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Tarnef Rebecca Kushner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 07079 609 W. South Orange Avenue, Stephen Schectman, #4D South Orange, NJ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 □ Removal from State Department of important: If any injury or once. injury or 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Garden 4/5/04 Falls Church, VA 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 21. Signature of Funeral Service Licensee 1170 Rockville Pike, Rockville, MD 20852 Jare 23a. Part1. Enter the disease shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner erel Director: After this cartificate has been signed by the attending physician and filled in by the funeral director, paga 2 should be datached for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. by Physician/Medical Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed TLI Yes 2 LINO 1 Yes 2 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩0 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 - Natural 1 Yes 2 No death. 2 ☐ Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or within 24 hours a To the Funeral D 1 Retrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0:44907 Une April 3, 2004 1-2mm m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONSUEZO Montre 31. Date filed (Month, Day, Year) APR 05 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 12852 1- State Registrar AMEND ITEM #12 PER INF G842 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Jack SHER April 2004 6:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 2205 Reedie Drive Wheaton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

8 5 yrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 85 Yrs. Oct. 28, 1918 Director New York 056-03-8194 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show rthan "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 1 ☐ Yes 2 XNo Maryland Montgomery Wheaton Funeral Director the 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 20902 United States 2205 Reedie Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or ite ury or other traumatic event, the Medical Exemina 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Salesman Toys and Novelties 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morris Sher Sarah Manessey ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2205 Reedie Drive, Wheaton, MD 20902 Sylvia Sher, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 04/09/04 permit. Pages Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) King David Memorial Garden Falls Church, VA 21. Signature of Fureral Se vice bicenses 22. Name and Address of Facility Torchinsky Hebrew Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest.

254 Carroll St., NW, Washington, DC shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Several Yrs **Physician** Chronic Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Several Yrs Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed c. Atherosclerosis Several Yrs Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) PO Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by Coronary Artery Disease 1 ☐ Yes 2 ₹ No 3 ☐ Probably 4 ☐ Unknown Hyperlipoproteinemia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? 1 Yes 2 No Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident death. investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after To the Funeral Direc 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified m.D April 7, 2004 D 0009215 aurence Marcies 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lawrence D. Marcus, M.D., 10313 Georgia Ave., Suite 207, Silver Spring, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 9 2004 Registrar

		•	For		ryland / Depa		lealth and	Mental Hyg	iene •g. No. 200	
	_		Registrar  1. Decedent's Name (First, Middle, Last)			inouto or .		2. Date of Dea		3. Time of Death
	Physicia /Medic	al	Jane Jongnam  4a. Facility Name (If not institution, give s	Shin		4b City Town o	r Location of Deal	Month April 1	Day Year	6:30AM
	Examin	er					ver Spri		Montg	
100		,	14709 Jaystone Dr. 5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	B Date of Birth	9.B	irthplace (State or Foreign Country)
The San	Funeral Director			M 2X)F 6	. Vre	Months Days	Hours Min.	Jan. 10		Korea
	and		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Maryl 3e-f sho	ctor	Maryland Montgo	mery			er Spring			1 ☐ Yes 2 X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show minipury or other traumatic event, I'm Medical Exist illust must be inclified at once.	by Funeral Director	10e. Street and Number 14709 Jaystone Dr	ive		10f. Zip Code 209	905	1	0g. Citizen of What 0	
	ms 2	Jer.	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	dispanic Origin? (S	Specify Yes or No-	14. Race - Ar Black, Wi	nencan Indian,
36	rs after	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2X N If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:	to ritoan, etc.,		Asian
Ş	tura F	ed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busines	ss/Industry
Maryland 21215-0036	ithin 72 ne. man "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5	life.	e kind of work done DO NOT use retired Iomemaker	during most of wo d)	prking		Own Home
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ė,	1 an Heal Heal		20a. Method of Disposition		20b. Place of Disponentery, cre			Date	20c. Location - City	
Baltimore,	No Time		1 ☐ Burial 2 ☐ Cremation 3 ☐ P  4 ☐ Donation 5 ☐ Other (Specify)				ł ·	/2 200A	Olney, Ma	rul and
Ħ	artme prrten injur		21. Signature of Euneral Service Licens							al Home, Inc.
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			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	lications that caused						Approximate Interval Between
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68	certificate nding phys	Jed	IF FEMALE:							
Вох		an/h	23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth		□Ectopic pregnancy	у		23d. Date of o	delivery Day Year
	0 8 9	SICI	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown	time of death 5[	Other (specify)				55,
P.0	d by t	Phy	Part II. Other significant conditions co	atributing to death by	it not reculting in the	inderlying cause an	ven in Part I	23a Did to	bacco use contribute	to the cause of death?
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Vit.	ysician: Th iis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		nt 30 DOA Ott		eath (Check only or		
of	Physical this all dir	2	1 Yes 2 No 27. Manner of Death	1 Unpatie	nt 2 ER/Outpatie	all SU DOX	4 🗀 Nulsing	-	ence 6 Other (S)	pecify)
n C	Jing Ph J. After th funeral	o	1 Natural 5 Pending	28a. Date of Inju- (Month, Da)	Year) Injury	Wo	rk? ]Yes 2 ☐ No	ESG. BOSCHOOT	on injury observed	
Sic	Attending Physician: if death. ector: After this certifici by the funeral director.	cat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Inju	ıry - At home, farm, si			28f. Location (S	treet and Number or	Rural Route Number,
Division of Vital Records,	al or A	Certification:	4 Homicide determined	building, etc	(Specify)	neet, factory, office		City or Tow	n, State)	
	To the Hospital or Attendwithin 24 hours after death To the Funeral Director: completely filled in by the	ledical (	29a. Certifier 1 XCertifying Phy (Check only one) 2 Medical Exami	rsician: To the best iner: On the basis of and manner sta	of my knowledge, dea examination and/or inted.	th occurred at the time to the	me, date and place opinion, death occ	ce, and due to the courred at the time, of	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	<u> </u>		29c. Licens	se number	2	9d. Date signed (Mo	nth, Day, Year)
			Lustin A	auth 1		D3	9104		April 2,	2004
	3		30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Type	, Print)				
			Kurtis A. Campbe	-			eet. #60	5, Baltin	nore, MD 2	1287
	St	ate	31. Date filed (Month, Day, Year)	32. Pegistr	ar's Signature	Sparks				
	Regist		APR 0 5 200	4 Spine	Jan 10	pours				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year **JOHNNIE** M. **SMITH** APRIL 2004 11:00 A /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2**X** F Yrs. 415-54-5866 Director 67 SEPT.22,1936 TENNESSEE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Expositive roust be notified at Director 1 Yes 2 □ No PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 4906 COLONEL ADDISON PL. 20772 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mentat Hygiene. Item 27 is marked other than "natural; or ite 1 Never Married 2 Married 1 Yes No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 ADMINISTRATIVE NATIONAL ZOO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental JOHN 2 SCHAICH DECIE ELLIOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUIS L. SMITH/HUSBAND 4906 COLONEL ADDISON PL., UPPER MARLBORO, MD.20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of the important: If ite any injury or ot once. injury or 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 4-6-04 RIVERDALE, MD. 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A ₹100091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VENTRICULAR FIBRILLATION resulting in death) /Medical Due to (or as a consequence of) Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit ATHEROSCLEROTIC CORONARY ARTERY DISEASE and Due to (or as a consequence of): Box 68760 the attending physician hed for use as the buria Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an autopsy performed?
1 Yes X No 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 DQA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident in by the within 24 hours after deatl To the Funeral Director: 6 Could not be 3 TI Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 057800 APRIL 6, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUHAMMAD ASHRAF, M.D. 5711 SARVIS AVE., SUITE 100, RIVERDALE, MD. 20737 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 Registrar

			1 - For	State of M	laryland	-	artment o			ınd Men	-	•	000	Į	10	Co. gette plane
			Registrer  1. Decedent's Name (First, Middle, La	ast)			incate	OI D	cairi	2.1	Date of De	Reg. N	0.2 11 11	-4	3 Time o	355
ı	Physici			arks							Month	D.	ay Ye	ear	5:00	Λ M
	/Medic Examin		4a. Facility Name (If not institution, gi		···		4b. City, To	wn, or L	ocation of		1111	-	c. County of (	Death	5.00	A
	LAGIIIII		Sunrise Assisted Li	ving of Mont	t. Villa	age	Montgo	mer	y Vil	llage			Montgo	mer	У	
	Funeral				ge (In yrs. las	st birthday)	If Under 1 Months		If Under 2 Hours		Date of Bir (Month, Da	th	9.	Birthpl	lace (State of	or Foreign
	Director		303-01-4477	1 □ M 2 🖾 F	88	Yrs.	NOTITIS	ays	riours		pt. 2			Ker	ntucky	7
	and *		Usual Residence of Decedent  10a. State 10b. County		10c, City.	Town or Lo	cation							10	0d. Inside C	ity Limite
	Manyl f sho	or	Maryland Montgom	erv		hersl								'`		2√E No
	288-	Director	10e. Street and Number		Juli	-110131	10f. Zip Co	ode				10a. C	itizen of Wha	t Coun	trv?	
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פ	e filec Il Hyg othe	Be C	17. Father's Name (First, Middle, Las	()						's Name <i>(Fir</i>	rst, Middle,	1				
<u> a</u>	Aenta Aenta rked rlc ev	To B	James Storey							Lue11	la He	ight	t			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene.  any injury or other traumatic event, the Muchical Examinar must be notified at once.		19a. Informant's Name/Relationship		1								or Town, Sta			
<u>≥</u>	and lealth m 27 her tr		Stephany Lee Bail	.ey/Daught					-		-		Maryla			
Baltimore,	it of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [	Removal from State	cen	netery, cren	sition (Name natory or othe	r olaca)	A	prilie			ocation · City			
₫	rtmer rtant		* 4 □ Donation 5 □ Other (Special Signature of Fune(all Service Lice		Crem	atori	gomery um, In	ic.		2004			nesda,			
Ba	Depa Impo any i		A A CO	MO1:	356								ohrey deny	Ave	enue,	iome,
			23a. Part1. Enter the disease, or con	plications that cause	d the death.	Do not ent	ckvill er the mode o	e,M f dying,	such as c	and 20 ardiac or res	J <u>850-</u> spiratory ai	280° rrest,		1	Approximat	е
	Pnysician ·		shock, or heart failure. List only Immediate Cause (Final				r - 41								Interval Bet Onset and I	
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8760	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal E														
99	ificate g phy: as the			. 0												
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ч О	at the de	by Physician/Me	9 Unknown							-						
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		S .	25. Was case referred to medical								1 ☐ Yes	2 <b>x</b> No			2□ No	
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	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier	^ /			29c. Li	cense n	umber			29d. Da	ite signed (Mo	onth, D	ay, Year)	
			D ALM	WAGA	al	, M	0 =	3/2	591	D	l A	Apri	.1 5, 2	2004		
(	0	1	30. Name and address of person who					-1-				-				
			Suhair H. Abulfar				Grove	Roa	d, #	100, R	lockvi	ille	,Maryl	and	2085	0
	Sta Registra	_	31. Date filed (Month, Day, Year)  APR 0 7 20		rar's Signatur	G	Spor	(2)								

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of h	Health and Death	Mental Hy	giene Reg. No. 200	4 12856
			Decedent's Name (First, Middle	e, Last)				2. Date of De	ath	3. Time of Death
	Physici /Medic		Robert Paul S	Sposato				Month April	8, 2004	1:09 PM
	Examin		4a. Fecility Name (If not institution			4b. City, Town, o	or Location of Dea		4c. County of D	
			Montgomery Ge			01ney			Montgo	mery
	Funeral		5. Social Security Number	6. Sex 7. Ag 1 ☑ M 2 ☐ F	ge (In yrs. last birthday 7 1 Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs Hours Min	. (Month, Da		Birthplece (State or Foreign Country)
	Director		127-24-9884 Usuel Residence of Decedent		71 Yrs.			Nov. 2	7, 1932 N	ew York
	/land		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Man	to	Maryland Mont	gomery	Silver S	oring				1 ☐ Yes 21 No
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a	rai	15101 Interla	chen Drive,	<del></del>	20906			USA	
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or freme 23s or 28s-f show aumatic event, the Madical Examiner must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	If Vac Give	Ever in U.S. 13. No 1956-60	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Specify Yes or No to Rican, etc.)	14. Race - A Black, W Specify: W	
9500-61212	2 hou	ted	15. Decedent	t's Education	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busine	ss/Industry
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7	d wit	Com		4		stment Ad	visor		Securit	Les
	d oth	Be	17. Father's Name (First, Middle,				18. Mother's Na	me (First, Middle	, Maiden Surname)	
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Maryland	12 sh and rem		19a. Informant's Name/Relations!  Barbara W. Sp			117.			er, City or Town, State	2000
	es 1 and 2 should b of Heelth and Ment item 27 is marked r other traumatic e	3	20a. Method of Disposition	JOSALO/ WITE	20h Place of Disn	nsition (Name of		Date	20c. Location - City	er Spring, MD
saitimore,	Pages nent of int: If it		1 ☐ Burial 2 ☑ Cremation		cemetery, cre	matory or other pla	111	ril 9,		
	permit. Pages Department of Important: If it any injury or once.		*4 □ Donation 5 □ Other (S)  21. Signature of Funeral Service I		Metropol	itan Crem 2. Name and Addre	atory		Alexandri	a, Virginia
ñ	Dep June Pen		Manus S	( ) mlan		Francis J	. Colling	s Funera	1 Home Inc	ing , MD 2090
7	- 13		23a. Part1. Inter the disease, or shock, or heart failure. List	complications that cause	the death. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			MORRH				Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):					4 9.373
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	sit 9d	inel	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
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200	ificate g phy as the	edic		d.						
. Box	death e atter	ician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No	4☐Pregnant at	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	/		23d. Date of o	lelivery Day Year
j	at the i by the	Physi	9 Unknown	9Ll Unknown						
ords,	w requires that the been signed by th should be detache	by	Part II. Other significant condition  ALZIHEZ M.	En DEMEN	_	inderlying cause giv	en in Part I.			to the cause of death?  Probably 4 □Unknown
1 Hecords	The law ate has b page 2 sh	Completed						24a. Was autor perfo 1 Yes	rmed2   death	autopsy findings available o completion of cause of ?
Vital	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	The second				ath (Check only o		
_	S S	ပ္	1 Yes 2 No		ent 2 ER/Outpatie	nt 3 DOA	er: 4 Nursing H	lome 5 Resid	dence 6 Other (S)	pecify)
2	fing F	ertification;	27. Manner of Death 1 ☑Natural 5 ☐ Pending		y Year) 28b. Time o	Wor		28d. Describe h	now injury occurred	
UNISION	death ctor: y the	licat	2 Accident investig 3 Suicide 6 Could r	not be aga Place of Init	ury - At home, farm, st		Yes 2 ☐ No	28f Location /5	Street and Number or	Rural Route Number
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	To the Hospital or Attending Ph within 24 hours after death. To tha Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical I	ng Physician: To the best of Exeminer: On the basis of and manner sta	f examination and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occu	a, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	f	·	29c. Licens	e number		29d. Date signed (Mo	
	4-11		3t. f	ow shue			3630		APRIL 8.	
	`		30. Name and address of person of FRNAK J. M.	who completed cause of d なりで、かり	leath (Item 23a) (Type,	Print) derick R	O #213,	buithe	where m	1 20877
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 9	2004 32. Registra	ar's Signature	Spark.				

			For State Registrar	State of M	Marylan		artment of			•	_	200	L	12857
		1. Decedent's Name (First, Middle, Last)								2. Date of De				3. Time of Death
	Physici /Medio		JESSIE STE	RATFORD						APRIL	4,	000		10:45P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, g				4b. City, Town		n of Death			County of D		
			Cherry Lane 5. Social Security Number 6.			er last birthday)	If Under 1 Ye	aurel	er 24 Hrs.	O Date of Bio				ORGES
A	Funeral Director		238-01-8444	1 <b>X</b> M 2□F	97.		Months Da			8. Date of Bir (Month, Da July	y, Year)	906	Country	e (State or Foreign arolina
4			Usual Residence of Decedent							Jary	- , -	J 0 9	14.0	dioiina
	arylar show	_	10a. State 10b. County  MD Prince	- Conward	1	, Town or Lo	Laurel	1					10d.	Inside City Limits
	he Ma 28a-t	Director	MD Prince Georges Laurel  10e. Street and Number 10f. Zio Code 10a											1 XYes 2 No
	with t		515 8th St	root			10f. Zip Cod	2070	7		-	zen of What U.S.A		?
	ours after death with the Marylar ral', or Items 23a or 28a-t ehow Exeminar must be notified at	Funeral	11. Marital Status	12. Was Deceden	nt Ever in U.	S. 13.	Was Decedent		-	ecify Yes or No		14. Race - A		Indian.
۵	or Iter	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces	No		Was Decedent of If Yes, specify C			Rican, etc.)		Black, W	hite, etc.	
3	72 hours after death with the Maryland Instural; or Items 23a or 28a-t ehow dical Examinar must be notified at	d by	3 2 Widowed 4 □ Divorced	If Yes, Give Year or Dates	:		1 □ Yes 2 <b>∑</b> 1	No Speci	ty: 			Specify:	Bla	CK
ည်	s within 72 hours giene. r than "natural", the Medical Exe	Completed	15. Decedent's l (Specify only highest g	Education rade completed)		(Give	dent's Usual Oc kind of work do DO NOT use rei	ne durina m	ost of worki	ng		nd of Busine		
7	within lene. than "	duic	Elementary/Secondary (0-12) 6th	College (1-4or	r 5+)		ntenar		orke	r	_	Laure Cours		ace
2	를 수렴 유	a l	17. Father's Name (First, Middle, Las	st)						(First, Middle,				
<u>a</u>		To B	Charles St	ratford					Lu.	la				
Maryland 21215-0036	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked eny injury or other traumatic e	, 8	19a. Informant's Name/Relationship			A	ng Address (Stre							
	and m 27 her tr		Delores Stra	atford (I	Daugh	The second second				t, Lau				
saltimore,	ges 1 It of H If ite		20a. Method of Disposition 1   Burial 2 □ Cremation 3		e ce	emetery, crei	sition (Name of natory or other p	place)		Date		cation - City		
	II. Pa		'4 □ Donation 5 □ Other (Spec		Ma	rylar	nd Mem.	. Par	k 4	/13/04	DITINI	Laure	1,	MD
g	Depa Depa Impo eny i		TONK !!	Inout	lea	2	246 N.	Wash	жу <b>З</b> М	POC POC	r UNI	ERAL	MOM.	E, P.A.
8)			23a. Part 1. Enter the disease, or con	mplications that cause	ed the death							LIC,	1	proximate erval Between
	Physician		shock, or   eart failure. List on! Immediate Cause (Final disease or condition			Th ron	nbosis						Or	erval Between iset and Death inutes
	/Medical		resulting in death)	- M	s a consequ		IDOSTS						1,1	Inuces
	Examiner	Examiner	Sequentially list conditions. if any, leading to immediate cause. Enter Undertying Cause (Disease or injury											
	nsit													
•	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or a	s a consequ	ence of):			_		_		-	
2/60	cate be executed oblysician and the burial-transit	dical		d										
200	death certificate e attending phys d for use as the	0		<u>.</u>										
X Q Q	leath certifica attending ph i for use as tl	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregna	ncv			2	3d. Date of c		
o n	e dea the att	sicl	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant a 9☐Unknown			Other (specify)					Month	Day	y Year
Ž.	hat the			contributing to death	hut not resu	lting in the u	adertving cause	gwee in Par	+1	23a Did to	pacco us	o contributo	to the e	auca of doath?
Vital Records,	vrequires that the de been signed by the should be detached	d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Cardiomyopathy								23e. Did tobacco use contribute to the cause of d  1 ☐ Yes 2 ☐ No 3 【※Probably 4 ☐ L			
Ö		Completed	Aortic S	tenosis						24a. Was	20	34h Wasa	autonou	findings available
T T	The larate has	dwc	MOTETE D	cenosis_						autop perfor	sy med?	prior to death	o comple?	ation of cause of
<u>E</u>	rician: The lav certificate has rector, page 2	0	25. Was case referred to medical					26. Pla	ce of Death	1 ☐ Yes (Check only o		1 🗆 Ye	9s 2□	No
	ding Physician: h. After this certific funeral director,	ToB	examiner? 1 ☐ Yes 🍇🛣No	Hospital: 1 Inpat	tient 2 🗆 E	ER/Outpatien	t 3 DOA	Out		ne 5 Resid		□Other (Sp	pecify)	
n of	ng Pl		27. Manner of Death  ∑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury	V	york?	2	28d. Describe h				
<u> </u>	tendi death. tor: A	cat	2 Accident investigation  3 Suicide 6 Could not be  3 Suicide 6 Could not be											
UIVISION	or Al after d Direct in by	Certification:	4 Homicide determine	d 289. Place of Ir	etc. (Specify)		et, factory, offic	Ce Ce	2	28f. Location (S City or Tow	itreet and m, State)	Number or i	Rura/Ro	ute Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifying P	hysician: To the besi	t of my know	vledge, death	occurred at the	time, date a	and place, a	and due to the	ause(s) a	and manner:	as stated	
	n 24 h	edical	(Check only 2 Medical Exa	aminer: On the basis and manner s	of examinati	ion and/or inv	estigation, in m	y opinion, de	eath occurre	ed at the time, o	date and	place, and di	ue to the	cause(s)
	To the To the comp	M	29b. Signature and title of certifier	11/1			29c. Lice	ense number	r		29d. Date	signed (Mo	nth, Day,	Year)
	4		11/1/4	1 1/01	renh	M	I	01391	.6		Αp	r. 6,	20	04
	-		30. Name and address of person who				,	C	0.5	C+ +	<b>N.</b>	-1 24	D	20707
			William A. Wo	arren, M	D. trar's Signati		Prince	Geor	yes :	ot., L	aure	= <b>⊥</b> , M	ע	20707
	Sta Registr		APR 0 8 2	004 Ses	and a	19	Span	b						

		State of Maryland / Dep	partment of Health and Menta ertificate of Death						
Physic /Medi		Decedent's Name (First, Middle, Last)     MILO SUNDERHAL	a M	ate of Death onth Day Year 3. Time of Death					
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death					
		DOCTORS COMMUNITY HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	LANHAM  If Under 1 Year   If Under 24 Hrs.   8, Da	PRINCE GEORGES  Atte of Birth 9. Birthplace (State or Foreign					
Funeral Director		115-24-3906  Usual Residence of Decedent	Months Days Hours Min. (M	ste of Birth (onth, Day, Year)  N. 31,1930  9. Birthplace (State or Foreign Country)  MA.					
or death with the Maryland tams 23e or 28e-f show at finat be notified at	tor	MD. PRINCE GEORGES 10c. City, Town or L	ocation GREENBELT	10d. Inside City Limits					
ith the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
ath w 3 23e	ra	402 RIDGE RD. #12	20770	U.S.A.					
72 hours after dea "natural", or flams	by Funeral	3 ☐ Widowed 4 X Divorced   If Yes, Give 1932	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes	es or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE					
	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv. life.  Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry					
be filed withing the filed withing the filed withing the filed withing the filed other them event, if the M	Con	5+ ECON	NOMIST/STATISTICIAN	FED. GOV'T.					
ylallo buld be fil Mental H arkad oti etic evan	To Be	17. Father's Name (First, Middle, Last)  GUNTHER SUNDERHAUF	18. Mother's Name (First	, Middle, Maiden Sumame) RED COBURN					
C, Mal y Co			ing Address (Street and Number or Rural Rout  DAHLIA CT., McLEAN,						
es 1 ar of Hea of Hea fitam r other	l s	20a. Method of Disposition 20b. Place of Disp		20c. Location - City or Town, State					
mit. Pages partment of cortant: If it injury or cite.		`4 □Donation 5 □Other (Specify) ORFORD C	EMETERY MAY 15,	2004 ORFORD, NH					
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service & Bensee  MO0091  MO0091	22. Name and Address of Facility HAMBERS FUNERAL HOME 801 CLEVELAND AVE., R	& CREMATORIUM,P.A. IVERDALE, MD. 20737					
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a xynsequence of):	ter the mode of dying, such as cardiac or respi	iratory arrest,  Approximate Interval Between Onset and Death					
te be executed ysician and he burial-transit	Ical Examiner	d	mory failu	V.C					
w requires that the death certifica vequires that the death certifica been signed by the attending phe should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year					
requires that the	by	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I. 23	Be. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown					
The larate has	Completed			Ia. Was an autopsy findings available prior to completion of cause of death?  Yes 20 No					
ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death (Chec						
) £ = =	tion: To	1  Yes No Hospital: 1 Inpatient 2  ER/Outpatie  27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury	Residence 6 Other (Specify)						
0 + 5 -	Sertification:	2 Accident investigation   M   1 Yes 2 No   3 Suicide   A Good Number or Rural Route Number,   Specify   28e. Place of Injury - At home, farm, street, factory, office   building, etc. (Specify)   28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To the Hospitel or within 24 hours after To tha Funaral Dir. completely filled in 1	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea (Check only one)  Certifying Physician: To the best of my knowledge, dea (Check only one)  A certifier (Check only one)	th occurred at the time, date and place, and dunvestigation, in my opinion, death occurred at the	e to the cause(s) and manner as stated. ne time, date and place, and due to the cause(s)					
24 /	W	29b. Signature and title of certifier	29c. License number P6 () 6 1 1	29d. Date signed (Month, Day, Year)					
		30. Name and address of p who c mpleted cause of death, (Item 23a) (Type PL Samuel Asfay 8118 Good Lu	M Rel Lonhon D	nd 20707					
St Regist	ate trar	APR 0 6 2004 32. Registrar's Signature	Sparks						

			For State Registrar	State o	f Marylan		artment o			-	giene Reg. No. 2 (	104	12859								
	Physici /Medi		1. Decedent's Name (First, Middle, La Carmela				M	ath 30, Day 200		3. Time of Death 12:14P M											
	Examir		4a. Fecility Name (If not institution, give street and number) Frederick Memorial Hospital					n, or Location		Fre	4c. County of Death Frederick										
	Funeral Director		5. Social Security Number 6. S 165-24-9134 Usual Residence of Decedent	ex □M 2ĂF	7. Age (In yrs. I	7 2 Yrs.	If Under 1 Y Months Da	ear If Und	s Min.	8. Date of Birt (Month, Day Oct. 18	h y, Υθας) 3, 1931	9. Birth Cou Pen	place (State or Foreign ntry) nsylvania								
	the Maryland 28e-f show	rector	10a. State 10b. County  Maryland Frederic  10e. Street and Number	y Town or Lo		de		10a. Citizen of	10d. Inside City 1 ☐ Yes  10g. Citizen of What Country?												
	3a or	O	6596 Waters Edge	Court			21	774				S.A.									
9036	be filed within 72 hours after death with the Maryland tal Hygiene. dother then "natural", or ttems 23a or 28e-f show event, the Medical Examinar must be notified at	d by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	·	<b>2</b> √⊡ No ⁄e		Vas Decedent f Yes, specify (			ify Yes or No- ican, etc.)	14. Rac	ce - Ameri ck, White,	can Indian, etc. ite								
21215-0036	within 72 h lene. then "natu ins Medical	Completed by	15. Decedent's E- (Specify only highest gra Elementary/Secondary (0-12)		-4or 5+)	(Give life. l	lent's Usual Ockind of work do NOT use re	oné during m ntired)		9	16b. Kind of B		·								
	filled Hygi other ent,	Be C	17. Father's Name (First, Middle, Last,			Out	COMCI			First, Middle,	Maiden Sumar		OII								
Maryland	d 2 should be filed within h and Mental Hygiene. 7 ia marked other then " traumatic event, the Max	To B	James V. Saccone			19b. Mailir	g Address (Str			Omodi	or, City or Town,	State. Zio	Code)								
	and 2 aith a 27 is er trau		Samuel Spadone (H	Husband)							arket,										
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If tlem 27 is marked any injury or other traumatic e once.		20a. Method of Disposition  1		State C6	emetery cren	sition (Name on atory or other crem.	place)	Da		20c. Location		own, State Maryland								
Balti	permit. Departri Importe any inju		21. Signature of Funeral Service Lion	X	ules	RC RC	Name and Ad BERT E	Idress of Fa	EY & S	ON FUN	ERAL HO	MES.	P.A.								
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that one cause on a		. Do not ente	er the mode of	dying, such	as cardiac or	respiratory ari	rest,		Approximate Interval Between Onset and Death								
		xaminer	xaminer	xaminer	xaminer	resulting in death)  Sequentially list conditions,	Due to	or as a consequ				7) 00.				Years					
						Examiner	xaminer	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
68760,	ificate be execute g physician and as the burial-trans	edicai	(	d																	
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/M	by Physician/M	by Physician/M	ıysician/M	ysician/M	nysician/M	ysician/M	ysician/M	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnant at time of death 5   Other (speed)						ctopic pregnancy Other (specify)				ery Day Year
Δ.					Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in							23e. Did to	Anne	cco use contribute to the cause of death?  2/X No 3 Probably 4 Unknown							
Il Records,		Completed							24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes		psy findings available npletion of cause of 2 No										
Vital	Physician: T this certificat al director, pa	Be	25. Was case referred to medical examiner?	Hospital:					ce of Death (	Check only or	16)										
of	his I di	on; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date (		R/Outpatient 28b. Time of Injury	28c. li	Other: 4 🗍			ence 6 Oth		1)								
Division	el or Attending P s after death. Il Director: After t id in by the funera	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place	of Injury - At hor	me, farm, stre		Yes 2		f. Location (Si City or Town		er or Rura	l Route Number,								
	Hospit 4 hours Funera	edical Ce	29a. Certifier Certifying Ph	ysicien: To the niner: On the ba and mann	isis of examinati	vledge, death on and/or inv	occurred at the	e time, date by opinion, d	and place, an	d due to the ca	ause(s) and ma ate and place, a	nner as st	ated. the cause(s)								
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	C and man	ei stateu.		29c. Lic	ense numbe	r	2	9d. Date signed	(Month,	Day, Year)								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							29c. License number D43091 29d. Date signed (Month, Date of the Second S														
	10		SAREN Z	AIDI	MI	23a) (Type, F	801 7	ou	House	= Au	z R	ede	nele								
	Sta Registr	1 m	31. Date filed (Month, Day, Year)  APR 0 2	2004 )	egiarar's Signati	ше	horse														

			1 - For State Registrar	State	e of Marylar		artment rtificate				nental Hy	ygiene Reg. No.	2004	12860
	D		1. Decedent's Name (First, Mid	dle, Last)		^					2. Date of D	eath		3. Time of Death
4	Physici /Medi		Nancy	FSa	noto	R.					March	30,	2004	4:12 A M
	Examir		4a. Facility Name (If not instituti	-	*		4b. City,	Town, or	Location (	of Death		4c.	County of Death	
			Washington A	dventist	Hospital		Take	oma	Park			Mo	ntgomer	У
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 <b>X</b>	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth	9. Birthp	lace (State or Foreign
	Director		577-44-4609	10 40	70	Yrs.					DEC.23	,1933	Tenne	essee
	and w		Usual Residence of Decedent  10a. State 10b. Coun-	ty .	10c. Cit	y, Town or Lo	cation				-		1	0d. Inside City Limits
	Aanyl Fsho	ō	Maryland Mont										] '	1 ☐ Yes 2 No
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show he Madical Examiner must be notified at	Funeral Directo	Maryland   Mont	gomery		Silve	r Spr					40- 011		
	with a or	Ö		DDT								TOG. Citiz	en of What Cour	itry?
	eath	era	2504 REDMILES  11. Marital Status	DRIVE	Decedent Ever in U	S 13		905	innania Ori	inin2 (Co	saifu Vas as Al	UNIT		
	ter d Item	5	1 ☐ Never Married 2 ☐ Ma	Armed	d Forces?	.3.	If Yes, speci	ify Cuba	n, Mexicar	n, Puerto	ecify Yes or N Rican, etc.)	0-   1	<ol> <li>Race - Americ Black, White,</li> </ol>	
336	urs af	þ	3 ☐ Widowed 4 🛣 Divorce	If Yes	, Give or Dates:		1 Tes 2	No.	Specify:			] .	Specify:	
215-0036	2 hou	pe	15. Decede	ent's Education		16a. Dece	dent's Usual	l Occupa	ation			16h Kin	Whit of Business/Ind	
15	n u	pie	(Specify only high Elementary/Secondary (0-12)	est grade complet		(Give	kind of worl DO NOT use	k done a	turina mosi	t of work.	ing	100.14	0 0 00000000000000000000000000000000000	200119
212	filed withi Hyglene. other ther	Completed	Elementary/Secondary (0-12)	Collec	ge (1-4or 5+)	Adm	inistr	cati	on			Pho	ne Compa	my
	filed Hyg othe	Bec	17. Father's Name (First, Middle	, Last)						er's Name	e (First, Middle			illy
ā	ould be i Mental I larked o	To B	Lester			Fraley			C1	ara			Hamilt	on
Maryland	2 should be filed within 72 hours after dea and Mental Hyglene. Is marked other then "naturel", or flems aumatic event, the Madical Examiner m		19a. Informant's Name/Relation	ship (Type, Print)			ng Address	(Street a			al Route Numb	er, City or	Town, State, Zip	
	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hyglene. Item 27 is marked other then "naturel", or Items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at		Kathryn Hoyle	/ daughta	a <b>r</b>								ring, MI	
ē,	s 1 a f Hei item othe		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name	e of	1		Date		ation - City or To	
Ë	Page ent o nt: If		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (	3 □Removal fr Soecify)	om State		-			/. /na	/2004	T	stown,Ma	
Baltimore,	permit. Pages 1 and. Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service		1	22	. Name and	Addres	s of Facilit	4/US	, 2004	Lewi	stown,Ma al Homes	ryland
ä	permit. Depart Import any inj		Balmon	0901	as in	10	)4 E.	Mair	n St.	/ Sta / Th	urmont,	mn	al Homes 21788	, P.A.
	ribline and		23a. Part1. Enter the disease, of	or complications th	at caused the death								21700	Approximate
			shock of heart failure. List only one cause on each line.											Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. tue to (r s a consequence of):											
и	Examiner			Q.	to (if as a consequ	Jence or):	man 1							
		ē	Sequentially list conditions, if any, leading to immediate	b. Due	to ()r as a consequ	uence of):	JUCY	2						
	nsit	들	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>1</b>	Ant	0	2001	_						
	al-tra	Examiner	that initiated events resulting in death) Last	c. Due	to (or as a consequ	Jence of):	rruc	<u>~</u>						
8760,	sate be executed oblysician and the burial-transit													
687	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		0.									-	
Вох	death certifica attending ph d for use as th	×	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome of pregna	ncy						25	ld. Data of dalive	
B	atter for u	ciar	in the past 12 months?		ve birth 2  Fetal		Ectopic pred		Van	00	polic	al-Ro	d. Date of deliver Month	y Day Year
P.0.	that the de ned by the a detached f	ysi	1 ☐ Yes 2 No 9 ☐ Unknown		nknown		, (2,50				Thomas	2000		
	res that igned b be deta		Part II. Other significant condit	ions contributing t	o death but not resu	Ilting in the ur	nderlying cau	use give	n in Part I.		23e. Did t	obacco usi	e contribute to the	e cause of death?
of Vital Records,	uires sign	d by	Dehudia	tion							12	Yes 2□	No 3 ☐ Proba	ibly 4 ∐Unknown
00	w require been si should b	Completed	Davaga	1500	-				_					
3e	has has	m m	Deples	RUM							24a. Was		prior to com	sy findings available pletion of cause of
a												3 No	death? 1 ☐ Yes 2	2□ No
Z:	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:							(Check only o	-		
of	d is	2	1 Yes 2 No	1 1		ER/Outpatien		Other	r: 4 □ Nur				□Other (Specify)	
L C	ing After une	Certification;	27. Manner of Death  Natural 5 ☐ Pendi		ate of Injury fonth, Day Year)	28b. Time of Injury		c. Injury Work			8d. Describe l	now injury	occurred	
Sic	ten seatl tor: the	cat	2 ☐ Accident Invest 3 ☐ Suicide 6 ☐ Could	not be			М		es 2□N					
Division	2 2 4 6	Ē	4 ☐ Homicide deterr	nined 286. Pi	ace of Injury - At ho iilding, etc. (Specify	me, farm, stre )	et, factory,	office		2	8f. Location (8 City or Tox		Number or Rural	Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by								-					
	To the Hospitel within 24 hours and the Funeral completely filled	edical	Check only 2 Madica	examinar: On the	the best of my know e basis of examinat	vledge, death ion and/or inv	occurred at estigation, in	the time n my opi	e, date and inion, death	i place, a h occurre	and due to the	cause(s) a	nd manner as sta lace, and due to t	ted. the cause(s)
	the the the	Med		and in	anner stated.									
1	7 1× 0		29b. Signature and title of certific	[	11 .		29c. 1	License	number /	-		29d. Date :	signed (Month, D	ay, Year)
•	in		Dean	mal	White	m	$\supset   \langle \langle \rangle \rangle$	00	775	53		3/	30/6	2004
	10		30. Name and address of person	_								-1		1
			Deanna White,	MD / 67	00 Carrol	1 Ave.	/ Take	oma	Park,	MD	20912			
	Sta	.c	31. Date filed (Month, Day, Year,		. Registrar's Signat	Ure A	Sagaretto	1						I
	Registr	ar	APR	1 2004	A STATE OF THE PARTY OF THE PAR	JE A								

			1- State of Maryland / Dep Registrar Ce	artment of Health and Men <i>rtificate of Death</i>	tal Hygier Reg. 1	
	<u> </u>		1. Decedent's Name (First, Middle, Last)		Date of Death Month	3. Time of Death
Н	Physicia /Medic		Hubert Ernest Snapp		ch 28,	2004 Tear 11:45P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death
			Frederick Memorial Hospital	Frederick		Frederick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year   If Under 24 Hrs. 8. 0   Months Days Hours Min. (4	Date of Birth Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		213-24-3362 1⊠M 2□F 76 Yrs.	Oc	t. 5, 19	
	pu 🖈		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L.	ngation		10d. Inside City Limits
	shov	_		ocation)		1 ☐ Yes 2 🔀 No
	Se-f	Director	Maryland Howard Mt. Airy			
	vith t		10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
	s 23s	by Funerai	2120 Cabin Branch Court	21771		ited States
	er de Itam	nu	Armed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc.
36	s aft	Ϋ́F	1 Never Married 2 Married 1 Married 2 No 11 No 11 No 12 No 12 No 12 No 13 No 14 No 1	1 ☐ Yes 2 💆 No Specify:		Specify:
Ş	turel	Pd t	1943-40	dent's Usual Occupation	16h	White Kind of Business/Industry
21215-0036	in 72	Completed	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	100.	Kind of Dusiness/Industry
72	with than	E C	Elementary/Secondary (0-12) College (1-4or 5+)	neral Contractor		Construction
0	filed Hyg other ent,		17. Father's Name (First, Middle, Last)	18. Mother's Name (Fire	st, Middle, Maide	
an	ld ba ental kad d ic ev	To Be	Samuel T. Snapp	Grace Eliza	hoth Du	dagill
Maryland	shou nd M mar imat	-		ng Address (Street and Number or Rural Ro		
Š	is 1 and 2. If Haalth ar item 27 Is other tree		Jane S. Snapp/ Wife 2120	Cabin Branch Court,	Mt Air	v Maryland 21771
ē,	t Haa Haan Ham tem otha		20a Mathad of Disposition 20h Place of Dispo	osition (Name of matory or other place)	20c.	Location - City or Town, State
5	ages ant of nt: If		1 12 POSTAL 2 CHARICAGO 3 CHARICAGO I STATE	Methodist Cemetery	,2004 De	magaia Marviland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "neturel; or Itams 23a or 28e-f show any injury or other treumatic event, the Medical Examinating must be notified at once.	1		2. Name and Address of Facility	Da	mascus, Maryland
Ba	Depar Impor any ir		tode original s	lin L. Molesworth P. 6401 Ridge Road, Dam	A. Fu	neral Home
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	ter the mode of dying, such as cardiac or res	piratory arrest,	Approximate
ret <sub>gi</sub>	Dharaisian		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	0 110		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Hemorhage		12-24
	Examiner		Act bable M.	d Hemorhage tostalis CA		
	o	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	uted d ansit	min	cause. Enter Underlying Cause (Disease or injury that initiated events  c.			
o,	exec in an ial-tr	Examiner	resulting in death) Last  Due to (or as a consequence of):			
68760,	icate be executed physician and s the burial-transit	edicai				
_	tifica ng ph as th					
Вох	eath certifi attending for use as	an/h	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 [	Ectopic pregnancy		23d. Date of delivery
	dea death	sici	1 Yes 2 No	Other (specify)		Month Day Year
0	The law requires that the death certifute has been signed by the attending rage 2 should be detached for use a	Physician/M	9 U ONKNOWN			
	gned be de	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		o use contribute to the cause of death?
ğ	w requir baan si should	ted	Anticoaquiation for		1 🗌 Yes	2 No 3 Probably 4 Honknown
ecc	e law r has be ge 2 sh	Completed	(R) Lonev ext DVT		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
m m	The ate h	mo.		1,	performed? 1 ☐ Yes 2 ☐ ★	death?
<u>ita</u>	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Che		
<b>_</b> _	Physic this ce al dire	P P	1 Yes 2 No Hospital: 1-Inpatient 2 ER/Outpatien	nt 3 DOA Other: 4 Nursing Home	5 Residence	6 ☐Other (Specify)
0	Attending Physicien: r death. ector: After this certifice by the funeral director, i	ü	27. Manner of Death 1. Natural 5 Pending (Month, Day Year) 28b. Time of (Month, Day Year) Injury	f 28c, injury at 28d, I Work?	Describe how inj	ury occurred
0	endii sath. or: A he fu	atic	2 Accident investigation	M 1 Yes 2 No		
Division of Vital Records,	l or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. L	ocation (Street a	and Number or Rural Route Number, ite)
	ral D					
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funaral Director: After this certificate his completely filled in by the funeral director, page	edicai	29a. Certifier Certifying Physician: To the best of my knowledge, deat (Check only 2 Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, and d vestigation, in my opinion, death occurred at	lue to the cause( the time, date a	s) and manner as stated.  nd place, and due to the cause(s)
	thin 2 the 1 the 1	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	5 iž 6	-	Say Signature and time or certifier		290. 0	/- (a)
-	20.		Charlotte	MO55104	)/	29/04
0	1+04		30. Name and address of person who completed cause of death (Item 23a) (Type,	Anymo 21771		
	Sta	10	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Try My CC771		
	Registr	. * **	MAR 3 0 2004	Goode		

DHMH 17 Rev 1/2001

Registrar

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DHMH 17 Rev 1/2001

State

Registrar

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APR

Please Type or Print In Black Indelible Ink. Assure All Copies Are Leable. State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 2.15 AM STEPhens TRUdie 3 04 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Nursing Home cluton MD Drine -uturecare Pure view N-Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthdav) 9. Birthplace (Stete or Foreign Country) Sex Months 1 M 2 PF 264-01-5537 26-1905 -lorida Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Montgomer ennsylvania 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 19406 ISA 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black Amer. 3 Midowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7' Grade Home None 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Pauline lillman Hankerson Lames 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) S. Gulph Road, King of Prossia phens 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 3 Other (Specify) Rolling Green Mem. Kark PO-West ( 21. Signature of Fundral Service Licenses 22. Name and Address of Facility 917 W. Isabella Street Bennie Smith Runeral Home Sulisbury, Maryland 21801 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOPUlmmar immediate Ceuse (Final disease or condition resulting in death) Carlure Due to (or es e consequence of) Due to (or as e consequence of)

Physician /Medical Examine: Physician/Medical Examiner

or Attending Physician: The law raquiras that the death certificate be executed

signed t

ate has bega 2 s

within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funerel dir

Completed by

Be

Medical Certification: To

Division of Vital Records, P.O. Box 68760,

Department of Heelth e important: if item 27 is any injury or other tra-

**Physician** 

/Medical

Examiner

10a. Stete

805

Director

Funeral

\$

Completed

**Funeral** 

Director

f Helith and Mental Hygiene.
If Helith and Mental Hygiene.
The first state of the first than "natural", or ferms 23s or 28s-f show other traumatic event, the Medical Examinan must be notified at

Peges 1 and 2 should be filed within 72 hours efter death

3altimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

melete Diahettes

Deculuti

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

			•		
		referred	to	med	dical
exan	niner?				
101	Vac	2 M No			

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

	71	163	-
ock	onh	onel	

1 ☐ Yes 2 ☐ No

Was case		to medica
examiner?		
1 Yes	2 No	

27. Menner of Death

28e. Date of Injury (Month, Day Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

28b. Time of

28c. Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1. Naturel 2 Accident 3 ☐ Suicide 4 ☐ Homicide 5 Pending investigation 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Tyes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated.

29b. Signeture and title of certifier

29c. License number 51520 29d. Date signed (Month, Day, Year)

3-29-04

13 DQ

State Registrar

Bahram fishdad 31. Dete filed (Month, Day, Yeer) MAR 3 1 2004

1328 Southern 32. Registrer's Signature SE Washington, DC 20032

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			1 - For State Registrar	State of M	•	epartment of i Sertificate of		,	giene Reg. No 2 {} {}	4 12865
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Lillian	Smit	:h			2. Date of Dea Month		3. Time of Death
	Examin		4a. Facility Name (If not institution, give s		0. (1.1		or Location of Death	n	4c. County of	Death
			5. Social Security Number 6. Sex		e (In yrs. last birtho	SAUS (av) If Under 1 Year		8. Date of Birti	Micon	
	Funeral Director			M 2 <b>X</b> F	86 Yr	Months Days		Nov. 12	1917 N	Birthplace (State or Foreign Country) [aryland
	aryland show	_	10a. State 10b. County		10c. City, Town o					10d. Inside City Limits 1 ☐ Yes 2 No
	the M	ecto	Maryland Wicomi  10e. Street and Number	.co	Quan	tico 10f. Zip Code	-		10g. Citizen of Wha	
	with se or	급	22210 Wetipquin	Poad			856		U.S.A	
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "neturel; or Items 23e or 28e-1 show other treumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status	2. Was Decedent Armed Forces?		13. Was Decedent of I If Yes, specify Cub		pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
900	ours after	i by F	1 Never Married 2 Married 3 Xidowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates:	NO	1 ☐ Yes 2 🛣 No	Specify:		Specify:	Black
5-0	72 h	etec	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. D	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	ation during most of wor	king	16b. Kind of Busin	ess/Industry
21215-0036	d within giene. or than	Completed	Elementary/Secondary (0-12)	College (1-4or	0+)	omestic	d)		None	
pu	ould be filed Mental Hygia arked other atic event, L	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
yla	should tind Ment marked	ပ္	Elijah McCoy					e Warre		
Maryland	d 2 sho th and 7 is ma treuma		19a. Informant's Name/Relationship (Typ			lailing Address (Street				
	Health tem 27 other tr	1	Orjetta Dashiell 20a. Method of Disposition	_	20b. Place of D	sposition (Name of		Date Date	20c. Location - Cit	
omi	0 0		1 Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	emoval from State		crematory or other pla 110w Cem	etery /	11/04	Quanti	co,Md. 21856
Baltimore,	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service License	Stewa	rt	22. Name and Addre Stewart 821 West	ss of Facility			
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused e cause on each li	the death. Do not					Approximate interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	ASC	VD					Onset and Death
	/Medical Examiner		resulting at death)		a consequence of)	VAS	DNICO	11011	1 4	
L		ner	Sequentially list conditions, any Loans to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as	a consequence of)	V 1 3	1 10 6 0	1000	111	
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		ERTE a consequence of)	ENSION	<u>J</u>			
68760,	tificate be executed ig physician and as the burial-transit	al E		*	1	ASCUL	AR	ACCID	ENT	
687	tificate ig phy as the	ledical								
O. Box	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant al 9□Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	y		23d. Date o Month	f delivery Day Year
ds, P.O	uires that I signed by d be deta	by	Part If. Dther significant conditions con	tributing to death b	ut not resulting in th	e underlying cause gr	ven in Part I.			te to the cause of death?  Probably 4 *** Onknown
Vital Records,	sicien: The law requir certificate has been si irector, page 2 should	Completed						24a. Was a autop:	sy prior	e autopsy findings available r to completion of cause of h?
a		e Co	25, Was case referred to medical				Of Place of Dog		2 <b>⊘</b> No 1□	Yes 2□ No
Ž	> 0 0	To B	examiner?	ospital:	ent 2 ER/Outpa	itient 3 DOA Oth	105		ence 6 Other (	Specify)
on of	두 두 교		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Tim	e of 28c. Inju	ry at rk?		ow injury occurred	
Division	deat deat ctor: / the	Medical Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm c. (Specify)	M 1	Yes 2 □ No	28f. Location (S City or Tow		or Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	dical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best er: On the basis o and manner st	f examination and/o	eath occurred at the ti r investigation, in my o	me, date and place opinion, death occu	, and due to the c rred at the time, o	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To the To the Comple	Me	29b. Signature and title of certifier	_		29c. Licens			29d. Date signed (M	
•			Detar. M.			05	7952		3/29/2	2004
<u>0</u> ç				1.D.	leath (Item 23a) (Ty 106 Mil	ford ST. =	# 504 r	3. Salis	bury. t	7021804
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 1 20		ar's Signature	5 Sport	h			

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			1_ For State	State of Marylar				nentai Hygi	000	11 1000
			= State Registrar		Cei	rtificate of	Death		g. No. 200	
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Brady Llewellyn	n Shafer				April	1 2004	10:10 PM
	Examin		4a. Facility Name (If not institution, give si			4b. City, Town, o	or Location of Death		4c. County of De	eth
			Wicomico Nursir	na Home		Salis	bury		Wicomio	co
	Funeral		Social Security Number     6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bi	irthplace (State or Foreign Country)
	Director		233–62–1075 <sup>1X</sup>	M 2□F 64	Yrs.	WOITING Days	Tiodis Mai.	August 24		hio
	2		Usual Residence of Decedent	100						1011 12 05 11 2
	how 1	_	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
:	6 B	cto	Maryland Wicomico	Sa]	isbury					1 X Yes 2 □ No
	deam with the maryland ms 23a or 28e-f show Tittual for malified at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
	238 238		328 North Division	Street		21801			USA	
	8118	Funeral	11. Marital Status	<ol><li>Was Decedent Ever in L Armed Forces?</li></ol>	J.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	
۰	or Ite	F	1 Never Married X Married	1 ☐ Yes 2 🛣 No If Yes, Give		1□Yes 2XNo			Specify: W	hita
2-0036	tural',	d by	3 Widowed 4 Divorced	Year or Dates:						
ດ	2 2 3	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done	during most of work	ring	6b. Kind of Busines	s/Industry
7	within ene. than "	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	inte.	DO NOT use retired	d)			
N	ygien ygien t, th		12	4+	Math	Teacher	40 Marked Name	e (First, Middle, M	Education	1
and	d off	Be	17. Father's Name (First, Middle, Last)					, , , , , , , , , , , , , , , , , , , ,		
	should be and Mental is marked ( aumatic ev	2	Charles William				Lola		Glassburr	
ā	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Typ		1	3			City or Town, State,	7 7
2	and ealth m 27 her tr		Martha Lee Shafer	(wife)					sbury, Ma	
Jore	m O		20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, crei	sition (Name of matory or other place	ce)	Date 2	Oc. Location - City o	or Iown, State
Ě	Pages nent of ant: If It ury or o		'4 ☐ Donation 5 ☐ Other (Specify)		rsons (	Cemetery	April	5,2004 S	alisbury,	Maryland
Ball	permit. Page Department important: if any injury or once.		21. Signature of Funeral Service License	9	H	Name and Addre	ess of Facility Funeral Ho	ome Profe	essional A	Association
n	20E = 9		Kit /C K	away CFSA						land 21804
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea e cause on each line.	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	HYPUXFMI		RESPIRAT	nP\i	PALLUO.		Onset and Death
-	/Medical		resulting in death)	Due to (or as a conse		ETSTIEVI	VI-)			
	Examiner			PNEU	KILLA	A				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):					
	le be executed ysicien and e burial-transit	Examiner	Cause (Disease or injury that initiated events	MCTASTAT	XX.	Colors	1 6	MYCER		
o	be executicien and burial-tran	EX	resulting in death) Last	Due to (or as a conse	q ence of):					
-	ysicie bu	cai	d							
9	res that the death certificate igned by the attending phys be detached for use as the	cian/Medi								
ROX	ondin use	2	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregn		75			23d. Date of de	elivery
ă	death e atten	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		]Ectopic pregnancy ] Other <i>(specify)</i> _	y 		Month	Day Year
	by the	Physi	9 Unknown	9□ Unknown						
 J	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
Vital Records,	an sig	D D	LENAL	FAILURE				1 ☐ Yes	2 □ No 3 □ F	Probably 4 WUnknown
ဂ ဂ		Completed	SEIZULE	DICAROTO				24a. Was an	24b. Were a	autopsy findings available
e E	The law te has b	Ę	JC CVLE	VISORVEIL				autopsy	prior to death?	completion of cause of
<u> </u>	n: I ficati x, pa	e Co	25. Was case referred to medical				OC Plans of David	1 Yes 2		s 2 No
5	ding Physician: The law th. : After this certificate has b funeral director, page 2 s	o Be	examiner?	ospital: 1 🗍 Inpatient 2 🖺	TER/Outpotion	oth oth		h (Check only one	ce 6 Other (Sp	
ō	this ald	<b> -</b>	27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe how		өспу)
5	Afte fune	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	f 28c. Injur Wor M 1 🗆	rk?  Yes 2∐No			
DIVISION	deal deal ctor: y the	lica	3 Suicide 6 Could not be	28e. Place of Injury - At h	nome, farm, str	eet, factory, office		28f. Location (Stre	et and Number or F	Rural Route Number,
≥ 1	after Dire	erti	4 Homicide	building, etc. (Spec	ify)	, , , , , ,		City or Town,	State)	
	purs burs merel filled		29a. Certifier 1 Certifying Phys	ician: To the best of my kn	owledge, deat	h occurred at the tir	me, date and place.	and due to the cau	use(s) and manner a	as stated
	24 h 24 h Fun	edicai		er: On the basis of examin and manner stated.						
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	₹ Ø	29b. Signature and title of certifier			29c. Licens	se number	290	d. Date signed (Mor	nth, Day, Year)
	- s - ō		Mad 1.	1	110	D	-00605	15	4/2/11	
1	1 4		30. Name and address of person who con	moleted cause of death /lte	m 23a) (Type	Print)	0000	,	17-100	1
1	i god		Mahesha Thimmar				nchore 5	orius C-	11	MD 01001
	Sta	ate	31. Date filed (Month, Day, Year) APR 0 5 2004	32. Registrar's Sign	ature 4	Sports	usnore L	rrve Sa	LISDURY	MD 21804
	Regist		APR 0 5 2004	Dener	July	pour				

unpend item#23a,27,28a-f,PER ME,G832,6/9/04eg Briana Elizabeth Scott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-02481 MAN State of Maryland / Department of Health and Mental Hygiene, 2004 For State Registrar amend #1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Day Physician 11, 2004 0935 A M Briana Elisabeth Scott /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Prince George's Hospital Center Cheverly
If Under 1 Year | If Under 24 Hrs. Prince George's 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours Min. Director 3 Jan. 8, 2004 Maryland None Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show ust be notified at 1X Yes 2 No Director Prince George's Maryland Capitol Heights 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23a 374 Possum Court 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status other traumatic event, the Medical Examiner permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event 1 X Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: À 3 Widowed 4 Divorced Year or Dates American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dave Brown Amanda Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Scott - Mother 374 Possum Ct., Capitol Heights, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 17 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 4/19/2004 Clinton, MD 21. Signature of Auneral Service License 22. Name and Address of Facility Stewart Funeral Home olm nower 4001 Benning Rd., N.E. Wash., DC 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Jause (Final Sudden Unexplained Death In Infancy Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a nonsequence of) burial-transit Exam and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Day 4 Pregnant at time of death signed by the at d be detached for 5 Other (specify) ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 XYes 2 No 1 Yes 2 🗌 No or Attending Physician: filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2□No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 No 4/11/04 death. investigation М sleeping in bed with mother 2 Accident after death i Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di residence 374 Possum Ct., Capitol Heights,MD 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Lasta ) Greenberg MM OCME April 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Tasha Z Greenberg MID 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 1 6 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1 Decedent's Name (First Middle Last) Day **Physician** 24 2004 March 11:35 a.m. Milton Calvert TEGELER, Sr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1140 Luther Drive Hagerstown
If Under 24 Hrs. 8 Date Washington If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 10XM 2□ F Yrs. Director 89 218-03-5259 May 28 1914 Maryland Usual Residence of Decedent the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after deeth v Department of Haalth end Mental Hygiene. Important: if item 27 is marked other than \*natural\*, or items 23a any injury or other traumatic event, the Medical Examines means Funerai 1140 Luther Drive 21740 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: à Specify: 3 AWidowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 0 Owner Lawn equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Milton Cleveland Tegeler Elizabeth A. Fryfogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11718 Robinwood Drive Hagerstown, Md. 21742 Milton C. Tegeler, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 3/27/04 Hagerstown, Maryland 21. Signature of Funeral Service Licenses Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed for use es the bunial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1\_ Yos certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 rursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 2 this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury death. 1 Yes 2 No investigation 2 ☐ Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical the Σ 29b. Signature and title of certifier 29c. License number 040622 5H-4 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BRN 657 U 2000 VI 6N DR 31. Date filed (Month, Pay 32. Registrar's Signature State

Registrar

			1 - For State Registrar	State of Maryland		artment of F			ene 20(	14 1287
į.	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  ALICE MA  4a. Facility Name (If not institution, give st	N/ O	35	4b. City, Town, o	r Location of Death	2. Date of Death Month 03(Much	4c. County of Dea	th
	Funeral Director		5. Social Security Number  219-34-5635  Usual Residence of Decedent	N 20€ 7. Age (In yrs. Ia.  M 20€ 67	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Sept. 8,		thplace (State or Foreign suntry)  Cyland
	the Maryland	Director	10a. State 10b. County  Maryland Washingt  10e. Street and Number		Town or Lo			10	g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2√2/No puntry?
326	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be invitified at	by Funeral Di	17831 Garden View	Road  2. Was Decedent Ever in U.S Armed Forces?  1	i	21740 Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert Specify:		U.S.A. 14. Race - Ame Black, Whit	erican Indian,
21215-0036	ad within 72 hou giene. er than "natura ; the Medical E	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occup kind of work done DO NOT use retired Homemake	during most of wor	king	6b. Kind of Business Personal I	
Maryland	δ la β 🐓	To Be (	17. Father's Name (First, Middle, Last) Samuel Younker	Corino)	40h Mailie	Address (Classes	Ru	th Heil		Tin Code)
	1 and 2 : Health au em 27 ls ther trau		19a. Informant's Name/Relationship (Typ  Marvin Twigg /Hus  20a. Method of Disposition  1X Burial 2 Cremation 3 Re	sband 20b. Pla	17831 ace of Dispo	5-11	View Road	Hagersto	City or Town, State,  Wn Vary1  Oc. Location - City or  Hagerstor	and 21740
Baltimore,	permit. Pages Department of Important: If It eny injury or o once.		21. Signature of Funeral Service Licensed		22	. Name and Addre	ss of Facility Dou	ıglas A. I	Fiery Fune	
Ħ	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Hypoxip		er the mode of dyin	ig, such as cardiad	or respiratory arres	st,	Approximate Interval Between Onset and Death
3760,	Examine and size price and size purial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	ateral ?	School	Š		
.O. Box 68	The law requires that the death certificat, ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of deal 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	ivery Day Year
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Division of Vi	ng Phys Iter this neral dii	ation: To B	examiner? 1 1 Yes 22 No Ho 27. Manner of Death 1. Natural 5 Pending 2 Accident investigation		R/Outpatier 28b. Time of Injury	Wor	er: 4 □ Nursing H		ce 6 □Other (Spe	cify)
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	X		30. Name and address of person who cor	mpleted cause of death (Item	23a) (Tyne	Print)	5307/	L	110-4 91	= 9m1-1
	Sta	ate	MARL S. RAPON  31. Date filed (Month Pay Year)  AR 25 20	MD 1110	1000	d you	5 R1.	Je [50	How Ton	MODIAZ
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			For	State of Ma	aryland		•			Mental Hy	giene	0.0	
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	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Madical Examiner must be notified at		28 Morning Mis					218			US	A 14. Race - Ame	alana tadina
	ter de Items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑		э.	If Yes, spe	city Cubi	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	1	Black, Whit	e, etc.
939	urs af	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2 <b>1</b> 00	Specify:			Specify: Whi	te
Maryland 21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grade			- (	Decedent's Usu (Give kind of wo	ork done	during most of wor	rking	16b. K	nd of Business	/Industry
121	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5	5+)		life. DO NOT L Teac		d)		FA	ucatio	nn -
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ary	2 should be filed within 72 hours after death with the Marylan and Mantal Hygiene. Is marked other then "natural", or liems 23a or 28a-f show tarmed to the title Madical Exertiner must be notified at aumatic event, it a Madical Exertiner must be notified at		19a. Informant's Name/Relationship (Ty			19b.	Mailing Addres	s (Street	and Number or Ru	ıral Route Numb	er, City o	r Town, State, 2	Zip Code)
2	다 57 블로		Timothy Tarr		not Di				Mist Dr	. Ocea			
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item eny injury or otha once.		20a. Method of Disposition  1 Burial 2 Cremation 3 F	emoval from State	CB	metery	Disposition (Na r, crematory or	other plac				cation - City or	
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<u></u>	icien: The certificate rector, pag						<u>-</u>			1 ☐ Yes	2 <b>X</b> O No	1 Yes	2 <b>⊠</b> No
Ž	Attending Physicien: r death. sctor: After this certifics by the funeral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ant 2 🗆 S	ER/Out	patient 3 D	Oth Oth	26. Place of Dea	ath <i>(Check only</i> dome 5 ☐ Res		S □Other (See	city)
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7	H, 10	_ '	GREGORIO M. BI 31. Date filed (Month, Day, Year)	32. Registr	m.D.	,53 ure	02 CHI	1ABC	ERRY DR.	SALISE	SURY	y, MD	21801
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		For State Registrar	State of Mar	ryland		ment of ficate of		d Mental H	ygiene Reg. No. 2 (	004	128
Physiciar /Medica		1. Decedent's Name <i>(First, Middle, Last)</i> EDNA FURNISS TA	YLOR					2. Date of D Month April	Day	Year 2004	3. Time of Dea
Examine	r	ta. Facility Name (If not institution, give s PONINSAM REGION	VAI Medic		Costar		or Location of De	IN	N.	y of Deeth	
Funeral Director		222-22-1370	7. Age ( M 2 1	(In yrs. I		f Under 1 Year Months Days	If Under 24 Hours M	8. Date of B lin. (Month, I 9 / 4 / 1	923	Counti	ice (State or Fo. 7) inia
the Maryland 28a-f show rotified at		Usual Residence of Decedent  10a. State 10b. County  MD Worceste			moke (					10	d. fnside City Li
death with the Maryland ms 23a or 28a-f show Linux Le rotified at	Direct	10e. Street and Number  1006 Market Str				10f. Zip Code 21851			10g. Citizen of		ry?
b 2 2 3	by Funeral Director		12. Was Decedent Ev Armed Forces? 1  Yes 2 No If Yes, Giver Year or Dates:					(Specify Yes or Nerto Rican, etc.)		ce - America ack, White, e	tc.
1215-0036 within 72 hours after see. Item natural, or like the Medical Examilira	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	)	16a. Deceden (Give kin life. DO Waitre	d of work done NOT use retire	pation during most of a	working	16b. Kind of E		•
be filed tal Hygin d other	Be	17. Father's Name (First, Middle, Last) Charles Elwood					Virg	Name (First, Midd inia Ma	le, Maiden Suma	me) st	
re, Mary	0.0	19a. Informant's Name/Relationship (Typer Phomas E. Martin		las: =	32341	Sign		Rural Route Num	Churc	h, VA	2341
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		20a. Method of Disposition  1	emoval from State	CE		ory or other pla Cemete	ry 4/	Date 8/2004		11, V	A
Balt  permit. Departi Import Import ony inj		21. Signature of Funeral Service License	Dean					olloway ssociat			
76(	cal Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a Due to (or as a	consequ	ence of):		Hemont	- 70			
P.O. Box 68 that the death certifical that the death certifical ded by the attending phy detached for use as the brush of the detached for use as the brush of the detached for use as the detached fo	by Physician/Medi	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal	death 3 □Ed	stopic pregnand ther (specify) _	y			ate of delivery	y Day Yea
w requires that been signed be deticated by the should be deticated by the state of	ed by Pi	Part II. Other significant conditions con	tributing to death but	not resu	Ilting in the unde	rlying cause g	ven in Part I.		tobacco use con		cause of deat
The law re rate has be page 2 sho	Completed							per	s an 24b. opsy formed? 2 No	Were autops prior to compleath?	sy findings ava pletion of caus
Of Vita	To Be	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 28a. Date of fnjury (Month, Day 1		ER/Outpatient 28b. Time of Injury	28c. Inju	her: 4 🗆 Nursin	Death (Check only g Home 5 ☐ Res 28d. Describe	- CART - FO		
Division To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	(Specify	)			City or To	(Street and Num. own, State)		
Hospital Hospital Hospital Hours a	Medical	29a. Certifier (Check only one)  1 ☑ Certifying Phys 2 ☐ Medical Examir 29b. Signature and title of certifier	ician: To the best of ner: On the basis of e and manner state	xaminat	wiedge, death or ion and/or inves	tigation, in my	ime, date and pla opinion, death or se number	ace, and due to the courred at the time	e cause(s) and m e, date and place, 29d. Date signe	and due to t	he cause(s)
the Ithe Ithe Ithe Ithe Ithe Ithe Ithe I	<b>5</b> i	200. DIGITALIS AND INTO OF CERTIFIC				LUCE LICET	-5		Lou. Date signe	Ja promitti, Di	, , . Gai/
To the I within 2. To the I complete	¥	30. Name and address of person who co					51359 Sha Na		Aprill	JE 20	04

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** April 3, 9:30 a <sup>™</sup> Dorothy Rebecca Thompson 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collington Episcopal Life Care Prince George's Mitchellville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. May 1, 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛱 F New Mexico 85 Director 525-01-7744 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits wods rai', or itams 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Maryland Prince George's Mitchellville Direct the 10e. Street and Number 10g. Citizen of What Country? 20721 10450 Lottsford Road, Apt. 2008 U.S.A. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural', d Mental Hygiene. narked other then \*natura natic event, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Executive Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be marked 2 Fred John Hennrich Clara Eva Wilson item 27 is me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence Henry Thompson - Spouse 10450 Lottsford Road, Apt. 2008, Mitchellville, MD other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 0 = 6 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury or once. Metropolitan Crematory 4/5/2004 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Ave., Hyattsville, Maryland 20781 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician DAYS Dreumonia resulting in death) /Medical Due to (or as a consequence of) **Examiner** MONTHS carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence ot) The law requires that the death certiticate be executed burial-transit Exam and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 DEctopic pregnancy ŏ in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. detached the 9 Unknown 9 Unknown ģ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records. 3 Probably 4 X Unknown 1 ☐ Yes 2 ☐ No Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Wasan page 2 autopsy performed? 1 ☐ Yes 24 No certificate Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) ٩ 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3□ DOA tuneral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident atter death in by the 1 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled within 24 hours a

To the Funeral C

completely tilled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature d title of certif 122780 0 who completed cause of death (Item 23a) (Type, Print) 7500 Greenway Ctr Dr. Greenbelt, MD 20770 Peter M Schiscler MD 31. Date liled (Month, Day, Year) . Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Eleanor Trozzo April 2004 2:30 Marie /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4012 Van Buren Street University Park Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye Jan. 1, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Sociel Security Number **Funeral** Months 1 □ M 2 X F 77 1927 Pennsylvania Director 181-22-5832 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County , or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Maryland Prince George's University Park Direct 10e. Street and Number 10g. Citizen of What Country? 4012 Van Buren Street 20782 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If I tem 27 is marked other than "natural", or Iten eny injury or other traumatic event, the Medical Experiment once. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephen Ference Mary Slekar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Phyllis Trozzo Page- Daughter 15616 Thistle Downs Court, Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 4/21/2004 Arlington, Virginia 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 Much 21 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atheroscletoric Cardiovascular Disease Years /Medical Due to (or as e consequence of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2 X No certificate 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ttle of certifié 40 D32261 April 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  $\mathcal{J}$ Richard J. Feldman, M.D., 9500 Annapolis Road, A-4, Lanham, MD ■. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 7 2004 Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** April 2004 12:50a M Thomas, Sr. William Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mariner Health of Silver Spring Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Fab. 9, 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1⊠M 2□F 578-28-9854 78 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be motified at Silver Spring 1 ☑ Yes 2 ☐ No Md. Montgomery Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 U.S.A. 901 Arcola Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government 12 Cleaning Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event ORE: Be Viola Coins George Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Duke St. Apt#Al Alexandria, Va 22304 William Thomas Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico National 4/9/04 4 ☐ Donation 5 ☐ Other (Specify) Triangle, Va 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Universal Mortuary Kennedy St. N.W. Wash. D.C. 411 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Advanced dementia of Alzheimer's type disease or condition resulting in death) years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 No 2 X No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 🔀 Nursing Home 5 🗌 Residence 6 🗆 Other (Specify) Hospital: Medical Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/OutpatienI 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 Yes 2 No investigation death 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) the Hospitel 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 4/5/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 Farragut Ave., Kensington, Md. 20895-2110 M.D. Rosenbaum, Barry 31. Date filed (Month, Day, Year)
APR 0 7 2004 State Registrar

ORIGINAL

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÷	+		1. Decedent's Name (First, Middle, La	ist)						Date of Death			Time of Death
	Physici /Medic		June Eleanor	Thompso	n					Month April	Day Ye 2004		:10 a M
	Examin		4a. Facility Name (If not institution, gi	e street and nu	mber)		4b. City, Town, or	Location of I	Death		4c. County of D	eeth	
4			Holy Cross Nursi	ng & Reh	nab Cen	ter	Bu	rtonsv	ille		Montg	omery	
,	Funeral		,	Sex	7. Age (In yrs.	•	If Under 1 Year Months Days	If Under 24 Hours		Date of Birth Month, Day,	(ear) g.	Birthplace Country)	(State or Foreign
	Director		5//-34-0859	1 □ M 2 ŪĀF	77	Yrs.				13,			gton, DC
	pu s		Usual Residence of Decedent  10a, State 10b, County		10c. C	ity. Town or Lo	cation					10d li	nside City Limits
	sho	ō	,	C1									Yes 2 No
	the N	Director	10e. Street and Number	George'	S	Lanham	10f. Zip Code			10	g. Citizen of What	Country?	
	deeth with the Maryland ms 23a or 28a-f show rmust be notified at			. 1			·			1.0		Country	
	ns 23	era	9893 Good Luck I		edent Ever in l	J.S. 13. 1	Was Decedent of H		n? (Specify	Yes or No-	USA 14. Race - A	merican In	ndian.
	riten	Funeral	1 ☐ Never Married 2 ☒ Married	Armed Fo	orces?	'	f Yes, specify Cuba	in, Mexican, f	Puèrto Rica	in, etc.)	Black, V	Vhite, etc.	
ğ	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir Year or D	ve lates:		1 ☐ Yes 2 ☑ No	Specify:			Specify:	Whit	e
Ò	filed within 72 hours after Hygiene. other than "natural", or Ite ant, the Medical Examire	Completed	15. Decedent's E (Specify only highest gi	ducation		16a. Dece	dent's Usual Occupa	ation	of working	1	6b. Kind of Busine	ss/Industr	у
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ם	9 7 5	Be	17. Father's Name (First, Middle, Las	t)							aiden Sumame)		
<u>  X</u>	should be fand Mental I and Mental I a marked of umatic eve	၉	Jasper Knight						en Pet				
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationship				ng Address (Street a			-		e, Zip Cod	e)
	and lealth m 27		Aloysius F. Thom	pson -			3 Good Lu	.ck Roa	id, La		MD 2070 Dc. Location - City	_	
0	Pages 1 and 2 should bent of Health and Ments of them 27 is marked jury or other traumatice		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 [		State	cemetery, crer	natory or other plac						State
Baltimore,	t. Pa ntmen rtent: njury		'4 □Donation 5 □ Other (Spec	The state of the s	Cec		1 Cemeter		4/6/2		uitland,		
Ba	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Serice Ligarity	May	1	47	2. Name and Addres 39 Baltin	nore A	Gasch venue	's Fune , Hyatt	eral Home sville,		A. 20781
	5		23a. Part1. Enter the disease, or con shock or heart failure. List ont	plications the	ed the dea	th. Do not ent	er the mode of dyin	g, such as ca	rdiac or re	spiratory arres	t,	Inte	roximate rval Between
. 7	Pnysician		Immediate Cause (Final disease or condition	Conge	estive	Heart I	Failure					Ons	et and Death
1500	/Medical		resulting in death)	W. Car	(or as a conse								
	Examiner		Sequentially list conditions,		e II Di								
	sit ad	lne	if any, leading to immediate cause. Enter Underlying Cause of the caus	Due to	(or as a conse	quence of):							
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587	licate phys s the	edical		_ d									
ŏ	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out							23d. Date of	delivery	
ň	d for	cial	in the past 12 months?		ointh 2 ☐ Fet nant at time of		Ectopic pregnancy Other (specify)				Month	Day	Year
o.	at the de by the a	hys	9 □ Unknown	9□ Unkn	owπ								
<u>ر</u> ري	res that igned to be deta	by P	Part II. Other significant conditions	contributing to d	eath but not re	sulting in the u	nderlying cause give	en in Part I.		23e. Did toba	cco use contribut	e to the car	use of death?
ğ	w require been sig should b	edi							_	1 🗌 Yes	2 □ No 3 □	Probably	4 ⊠Unknown
Records,	law re las be	Completed								24a. Was an autopsy	24b. Were	autopsy fi	ndings available ion of cause of
	The laste has page	mo;								performe	ed?   death	1? ∕es 2□:	
Vital	sicien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of	f Death (Cf	neck only one			
	hysic this ce al dire	2	1 ☐ Yes 2 💥 No	Hospital:	Inpatient 2	ER/Outpatien	t 3□ DOA Othe	er: 4 🔀 Nursi	ing Home	5 Residen	ce 6 Other (S	Specify)	
0	Attending Physicien: ir death. ector: After this certific by the funeral director,		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work	at c?	28d.	Describe how	injury occurred		
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Division of	I or Attend after death Director: v	Certification:	4 Homicide determined	200. Flace	e of Injury - At h ing, etc. <i>(Spec</i>	nome, farm, str ify)	eet, factory, office			Location (Stre City or Town,	et and Number oi State)	' Rural Rou	ite Number,
_	Hospitel or 24 hours afte Funerel Dir tely filled in		29a. Certifier 1 🔀 Certifying P	hypician: To the	haet of my kn	owledge death	n occurred at the tim	o data and s	place and	due to the sau	so(s) and manner	a a stated	
	Hos 24 hc Fun etely i	edical	(Check only 2 Medical Exa	miner: On the b	asis of examin	ation and/or in	vestigation, in my of	pinion, death	occurred a	t the time, dat	se(s) and manner and place, and	due to the	cause(s)
	To the Hospitel within 24 hours a To the Funerel Completely filled	Me	29b. Signature and title of certifier				29c. License	number		290	I. Date signed (Me	onth, Day,	Year)
			MALLIN	90	lolin	neut	22	5348	3	A	pril 2,	2004	
_	(5)		30. Name and address of person who	completed caus	se of death (Ite	m 23a) (Type,	Print)						- 17 <del>2</del>
	9		Marcia Goldmark,	M.D., 1	1906 <b>-</b> G	Darnes	town Road	d, Nor	th Po	tomac,	MD 2087	78	
	Sta	te	31. Date filed (Month, Day, Year)	<b>A</b> n □	logistror's Sign	atura							
	Registr	ar	APR 0 7 200	Dead	time . M.	Space	a						

			- FOI	artment of Health and Mental Hygien rtificate of Death Reg. N	.2004 12877
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Guyreid Hiram Thrower  4e. Fecility Neme (If not institution, give street and number) Woodside Center	April 5,  4b. City, Town, or Location of Death	c. County of Death
	Funeral Director		5. Social Security Number 5 7 8 - 9 6 - 3 0 4 3  Usuel Residence of Decedent		9. Birthplace (Stete or Foreign Country) 1969 Wash. DC
	the Maryland 7.28a-f ahow	rector	10a. State 10b. County 10c. City, Town or I Washir 10e. Street and Number 729 Park Road NW	ocation Ligiton	10d. Inside City Limits 1 ☐ Yes 2 ☑ No  Citizen of What Country?
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Menfall Hygiene. Department of Heath and Menfall Hygiene.  Bany injury or other traumatic event, tra Medical Examinal must be invitified at anone.	y Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married If Yes, Give	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:	USA  14. Race - American Indian, Black, White, etc.  Specify: D. 1
VO-01717	within 72 hours iene. 'than "naturel', I'e Medical Exi	Completed by	3 ☑ Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	e kind of work done during most of working  DO NOT use retired)	Black Kind of Business/Industry  rles County Gov'
yldliu	should be filled nd Menfal Hyg i markad other imatic event,	To Be C	17. Father's Name (First, Middle, Last) Carl Stokes	18. Mother's Name (First, Middle, Maide Gail Thrower	
2	and 2 sho ealth and n 27 is m		Gail Thrower/ Mother 729	ing Address (Street and Number or Rural Route Number, City Park Rd. NW Washington	DC 20010
ב	permit. Pages 1 Department of Hi Importent: If iter any injury or oth		1 □ Bunal 2 □ Cremation 3 □ Hemoval from State  1 □ Donetion 5 □ Other (Specify)  21. Signature of Funeral Service Incensee	matory or other place) 04-10-2004	
,00	Physician /Medical Examiner special and physician and physician and physician and physician are physician at the physician are physician at the physician are physician at the physician are physician at the physician are physician at the physician are physician at the physician are physician at the physician are physician at the physician are physician at the ph	cal Examiner	23a. Part 1. Enter the disease, or compiler tions that caused the death. Do not enshock, or heart failure. List only obe cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	pired Immundeficiency	Inferval Between Onset and Death  Synchrome Flours  Weeks
O. DOX 00	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
ras, r.	quires that I on signed by uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the		ouse contribute to the cause of death?
ו הפכטו	The larate has	Completed		24a. Was an autopsy performed? 1 □ Yes 2 ☒ N	
VIE	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check only one)	- To: 10 11
5	ding Phys h. After this funeral di	⊢	1 Yes 2 No 1005 1 Inpatient 2 ER/Outpatient 2. Sept. Outpatient 2. Sept. Outpatient 2. Sept. Outpatient 2. Sept. Time (Month, Day Yeer) Injury	of 28c. Injury at 28d. Describe how inj	
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director,	ertification:	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined (Month, Day Yeer) Injury 28e. Place of Injury - At home, farm, s building, etc. (Specify)	Work?  M 1 □ Yes 2 □ No	and Number or Rural Route Number, te)
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	ledical C	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, and due to the cause( nvestigation, in my opinion, death occurred at the time, date an	nd place, and due to the cause(s)
	To t com	×	29b. Signature and title of certifier  Rakush and GA	11) D20108 L	late signed (Month, Day, Year)
_	9		30. Name and address of person who completed cause of death (Item 23a) (Type Rukesh Arak MD 14300 Gallan	1 2 2 2 2 1	Bowie Md.
	Sta	ate	31. Date filed (Month, Day, Year)  APR 0 6 2004		

			1 - For State Registrar		aryland / Depa		Health and I	Mental Hygie	•	. 12878
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, L     Eileen Barb  4a Facility Name (If not institution, g     Suburban Hospit	ara Tenn		4b. City, Town, o	or Location of Death	2. Date of Death Month April 3 3	2004 Year 2004 4c. County of Dea Montgome1	
***	Funeral Director		5. Social Security Number 577.~34.·0449 Usual Residence of Decedent	Sex 7. Ag	e (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign
	the Maryłan 28a-f show notified at	Director	Maryland Montgo	mery	10c. City, Town or Lo			100	ı. Citizen of What Co	10d. Inside City Limits 1 ▼ Yes 2 □ No
	h with	I DI	3934 Lantern Dri	ve		20902			U. S. A.	
980	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28e-1 show ha Medical Exercitor critist by revitited at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Amed Forces? 1  Yes 2 1 1 Yes, Give Year or Dates:	No	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerlo Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	d within 72 ho piene. r than "natu	Completed	15. Decedent's (Specify only highest g	rade completed) College (1-4or 5	(Give life.		pation during most of work d)	king	b. Kind of Business	
nd 2	illed Hygi other ent,	Be Co	17. Father's Name (First, Middle, La.	2 Years	Seci	retary	18. Mother's Nam	ne (First, Middle, Ma		Government
ylaı	should be f nd Mental P marked of	To E	Fred M. Raybu	rn			Sylvia J	urner		
Jar	2 sho		19a. Informant's Name/Relationship					ral Route Number, C		
e,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury of ether traumatic evones.		Bernard I. Tenn 20a. Method of Disposition	- Husband	3934 20b. Place of Dispo		Drive, Si		ng, Mary1 c. Location - City or	and 20902
Baltimore,	ages int of int		1 ☐ Burial 2 🛣 Cremation 3		cemetery, crei	natory or other pla		A		
IĦ	artme ortan injury		<ul> <li>4 ☐ Donation 5 ☐ Other (Spec</li> <li>21. Signature of Funeral Service Lig</li> </ul>			tan Crem Name and Addre		6/2004 A1	exandria,	Virginia
Ba	Dep Imp		Donald C	States	· · · · · · · · · · · · · · · · · · ·	Edward Sa	gel Funer	al Direct	ion, Inc.	land 20852
	Physician /Medical Examiner  bubsician and physician and physician and physician and physician are street physician and physician are street physician and physician are street physician and physician are street physician are street physician and physician are street physician are s	l Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Conge Due to (or as Sever b. Due to (or as c.	estive Hear a consequence of): ce Chronic a consequence of): a consequence of):	t Failur	e			Approximate Interval Between Onset and Death
P.O. Box 68760,	res that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy	,		23d. Date of deli Month	ivery Day Year
	uires tha signed id be de	by	Part II. Other significant conditions  Chronic Atrial				ren in Part I.		co use contribute to	the cause of death?
Il Records,	: The law requires cate has been sign page 2 should be	Completed	Rheumatica, Di	abetes Mell	itus			24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		011		h Check onl one		
of	ing Phys After this uneral dir	ation: To	1 Yes 2X No  27. Manner of Death  1 X Natural 2 Accident  2 Accident	28a. Date of Injui (Month, Day	nt 2 ER/Outpatien  y Year)  28b. Time of Injury	28c. Injur Wor	y at	ome 5 Residence 28d. Describe how	e 6 □Other (Specinjury occurred	city)
Division	tal or Attend rs after death al Diractor: , ed in by the f	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Ru State)	ral Route Number,
	To the Hospital or At within 24 hours after of to the Funeral Diraci completely filled in by	edical	29a. Certifier (Check only one)	hysician: To the best of the basis of and manner sta	examination and/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur.	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier	- ,		29c. Licens D265			Date signed (Month	
7	[D		9	completed cause of de		Print)				UT
	Cto	10	Irving Mizus 3		ar's Signature			hesda Ma	ryland 20	0817
	Sta Registr	-	31. Date filed (Month, Day, Year) APR 05	2004	we B	Spork	2			

			State of Maryland / Department of Health ar			12070
			1 - Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)	2. Date of Dea	leg. No.2004	3. Time of Death
	Physici /Medic		CHARLES THOMPSON	Month 4	Pay Year	1 1-5 A
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of I	Death	4c. County of Dea	
	Funeval		6001 Muncaster Mill Road, Casey House Rockville  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth	Montgor 9. Bir	
	Funeral Director		214 42 3349 19XM 2 F 59 Yrs. Months Days Hours	Min. 8. Date of Birth (Month, Day May 22	1944 Was	thplace (State or Foreign ountry) nington, D.C.
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryla -f eho	tor	Md. Montgomery Olney			1 □Yes 2 No
	th the or 288	irec	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	ountry?
	ath w	ral	3030 O'Hara Place 20832		United Sta	
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ortainent of Health and Mental Hygiene. ortaint: If itam 27 is marked other than "natural", or items 23e or 28e-1 ehow injury or other traumatic event, the Medical Exam an roual terrofilied at 8.	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, If Yes, Specify: Yes, or Dates:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whit	
2-0	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most o	of working	16b. Kind of Business	/Industry
121	vithin ne. han "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	Working	County	
9	filed v Hygie othar t	0)	12 0 Firefighter  17. Father's Name (First, Middle, Last) 18. Mother's	s Name (First, Middle, I	Fire Depar	rtment
Baltimore, Maryland 21215-0036	Mental Mental arkad c	To B	Charles R. Thompson, Sr. Haze		uver	
Mar	id 2 sho Ith and 27 is m traum		19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number of Street and Number		, City or Town, State, 2 Nd. 20832	Zip Code)
re,	of Heal	1	20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or	Town, State
imo	Page ment cant: If	١.	I Burial 2 Acremation 3 Premoval from State	4/3/04 A	Alexandria,	, Virginia
Ball	permit, Page Department Important: If any injury o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Muriel H. Barb			20002
			23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as calculations, or heart failure. List only one cause on each line.	B,Laytons v Irdiac or respiratory arm		2088 Z Approximate Interval Between
P	Physician /Medical		Immediate Cause (Final disease or condition a. METASTATIC CARCINOMA a. METASTATIC CARCINOMA		· · · · · · · · · · · · · · · · · · ·	Onset and Death MONTHS
	Examiner		PROSTATE CANCER			YEARS
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
<u>,</u>	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8760,	ate be nysicia he bur		d			
9	ertifica ding ph	/Med	IF FEMALE:			
Вох	death certific e attending p id for use as i	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)		23d. Date of del Month	ivery Day Year
P.O.		hysi	9 Unknown 9 Unknown			
	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to es 2 No 3 ☐ Pr	o the cause of death?
of Vital Records,	The law ate has b page 2 si	Completed		24a. Was a — autops perforn 1 ☐ Yes 2	y prior to a	topsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	examiner?	Death (Check only on	8)	
of	ys die	. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ng Home 5 Reside	nce 6 ther (Spec	city) HOSPICE
ion	Attanding r death. actor: After by the fune	atior	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
Division	F 6 F C	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number or Ru , State)	ıral Route Number,
	Hospital of the sale of Funaral Distribution of the sale of the sa		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	place, and due to the ca	tuse(s) and manner as	stated.
	he Ho in 24 h ihe Fui	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	occurred at the time, da	ite and place, and due	to the cause(s)
	To the le within 2.	Σ	29b. Signature and title of certifier  29c. License number	29	9d. Date signed (Monti	
7	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		APRIL 3,	2004
_	•		EUGENE P. LIBRE, M.D. 10400 CONNECTICUT AVE.,	KENSINGTON	, MD. 208	95
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature & Apauls!			
	riegisti	<b>ш</b>	APR 0 5 2004 A FIFTH APPROVED			

		1- For State of Mary		artment of Health and		ene g. No. 2001	· 12880
		Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
Phys /Me	ician dical	Phuong Kim	Tran		April	L, 2004	12:18 A M
	niner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De	eath	4c. County of Deal	th
		Suburban Hospital  5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	Bethesda If Under 1 Year   If Under 24 H	Irs. 8. Date of Birth	Montgom	
Funer: Directo		214-82-1915 1\overline{\text{SM}} \text{M} \text{2} \sqrt{F} 7			lin. (Month, Day,	1926 V:	thplace (State or Foreign buntry) ietnam
		Usual Residence of Decedent			, , , ,		
arylar show	_		c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
he Mi	Director	Maryland Montgomery	Pot	omac		- 02	
with t		8604 Tuckerman Lane		10f. Zip Code 20854	10	g. Citizen of What Co	•
death ms 23	Funeral	11. Marital Status 12. Was Decedent Ever	in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	United St	
after o	Ē	Armed Forces?  1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No			ierto Rican, etc.)	Black, White	e, etc. Asian
2-UCSO 72 hours af natural', or	d b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:				Specify:	ASIAII
72 h	ete	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of v DO NOT use retired)	working 10	6b. Kind of Business/	Industry
d withir giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5+	Vietr	namese Ambassado: ted States	r to the ]	Diplomat	
filed Hygi other	Be	17. Father's Name (First, Middle, Last)	UILL		Name (First, Middle, Ma		
Daililliore, IMaryliatin Z.I.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Interpretent: If tien Z1 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, It a Medical Examinations the multilist at	ToB	Thang Van Tran		Khoan	Thi Tran		
Mary d 2 sho d 2 sho th and h 7 is ma trauma		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or		•	•
e, IV 1 and 1 ealth 3m 27 ther tr		Tin Vu Tran/Wife		Tuckerman Lane,			
ges 1 Fight of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	Ob. Place of Dispo cemetery, crei	matory or other place) Apr:	il 7,	oc. Location - City or	Town, State
Darillinor Dermit. Pages Department of I mportent: If its	0				004 B	ethesda, M	faryland
Demi Depa Impo	OUC9.		100170 30	2.Name and Address of Facility Dbert A. Pumphre O West Montgomery	y Ave., Rock	ville, MD	ille, Inc. 20850-2805
		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dying, such as card	liac or respiratory arres	t,	Approximate Interval Between Onset and Death
Physicia		Immediate Cause (Final disease or condition resulting in death)  Lung Canc	er				Six Years
/Medica		Due to (or as a co	nsequence of):				
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a co	nsequence of):				
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
O, exec an an rial-tr	Exa	resulting in death) Last Due to (or as a co	nsequence of):				
ate be ex thysician	dical	d					
as tiffic o	Mec	IF FEMALE:					
Buth cer attendin for use	Physician/M	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pi	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deli Month	ve <i>r</i> y Day Year
the d	ıysk	1 Yes 2 No 9 Unknown 9 Unknown	or death 3L	J Other (specify)			
s that	by Pl	Part II. Dther significant conditions contributing to death but no	ot resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
w requires ly been signed should be	ed b				1 X Yes	2 □ No 3 □ Pro	obably 4 Unknown
law re as bec	plet				24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
The The ate h	Completed				performs	gd?   death?	
VII.di ician: T sertificat ector, pi	Be	25. Was case referred to medical examiner?			Death (Check only one)		
Physi this c	2	1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient  27. Manner of Death 28a. Date of Injury	2 ER/Outpatier		Home 5 Residen		pify)
ding h. After funer	tion	1 Natural 5 Pending (Month, Day Ye	ar) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Atten deat deat ctor:	fica	3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm, str		28f. Location (Stre	et and Number or Ru	ral Route Number,
alor alor alor alor alor in Director	Certification:	4 Homicide determined building, etc. (S	pecify)	,	City or Town,	State)	
UNISION VICE IN THE TO THE HOSPITAL OF THE PAY WHIN 24 HOURS after death.  To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2	edical (	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my one and manner stated.	y knowledge, death mination and/or in	n occurred at the time, date and pla vestigation, in my opinion, death oc	ace, and due to the cau courred at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
To th. Within To the	Me	29b. Signature and titleyof certifier		29c. License number	290	I. Date signed (Month	n, Day, Year)
		10 CM		D45880	A	pril 1, 20	004
		30. Name and address of person who completed cause of death					
	Chair	Leon Hwang, M.D. 1221 Mercal	ntile Lar	ne, Largo, Maryl	and 20774		
	State istrar	APR 0 5 2004	0	pports			

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H <i>rtificate of L</i>			iene 9. No. 20 (	12881
	D		1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month	h Day Ye	3. Time of Death
	Physicia /Medic		Elmer	Truitt				March 3	0, 2004	10:30 PM
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4c. County of D	Death
			202 South Coll	ins Street		Snow Hi	11		Worces	
	Funeral				ge (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, December	Year) 9.	Birthplace (State or Foreign Country)
	Director		214-36-5190	1 <u>2</u> 1	67 Yrs.			December.	19,1936 M	aryland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Manyl 1 sho	ō	16 7 . J F7	. <b>L</b>	Const. Hi	7.7				1. Yes 2 □ No
	the 28a-	Director	Maryland Worces  10e. Street and Number	cer	Snow Hi	10f. Zip Code		10	Og. Citizen of Wha	t Country?
	3a or		000 0 11 0 11	Qbb		21062			TICA	
	72 hours after death with the Maryland natural', or Items 23s or 28s-f show disal Examinat must be rollikad st	Funerai	202 South Colling 11. Marital Status	12. Was Decedent		21863 Was Decedent of Hi	ispanic Origin? (Sp.	ecify Yes or No-		American Indian,
(0	r iter	표	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?		If Yes, specify Cuba		Rican, etc.)	Black, V	Vhite, etc.
8	al', o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify:	White
21215-0036	72 ho	Completed	15. Decedent' (Specify only highest		16a. Dece	dent's Usual Occupa	ation during most of work	ina 1	16b. Kind of Busine	ess/Industry
7	within ene. then "c	nple.	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired	)	9		
7	e filad within al Hygiene. I othar then ' vant, Ite Me	S	7		Wate	erman			Seafood	
pu	be filad within 72 hours after death with the Marylan ital Hyglene. Indocthar then "natural", or liems 23a or 28a-1 show event, the Medical Examinar must be rediffed at	Be	17. Father's Name (First, Middle, L	ast)			18. Mother's Name	e (First, Middle, M	faiden Sumame)	
돌	should be nd Mental marked o	ဥ	Griffen	Truitt			Ida -	Dav		
Maryland	2 8 8	1	19a. Informant's Name/Relationsh			ing Address (Street a				
	1 and Health em 27		Rosemary Frost	(niece)	8680	W-0.000 NO	Road, New			1841
0	gas 1 all of Heal If item or othe		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation	3 □Removal from State	20b. Place of Disp cemetery, cre	matory or other place	θ)	Date 2	20c. Location - City	or lown, State
Ë	. Pattment tant:		*4 □Donation 5 □ Other (Sp			Cremator		2, 2004		ry, Maryland
Baltimore,	permit. Pagas Department of I Important: If ite any injury or of		21. Signature of Funeral Service	icensee	H	2. Name and Addres Olloway F Ol Snow H	uneral Ho ill Road	ome Profe	essional urv, Mary	Association land 21804
			23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that caused	d the death. Do not en					Approximate Interval Between
	Physician		Immediate Cause (Final	M - + 2	to Ca	/	O 1-			Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of):	Lough	ed ca	mar		4 months
н	Examiner					× ×				
		Je	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):					3/1
	outed ad ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
oʻ	an ar irial-t	Ĕ	resulting in death) Last	Due to (or as	a consequence of):					
38760,	ficate ba executed physician and is the burial-transit	dical		d						
_	ng pt	•	IF FEMALE:						-1-	
Вох	death certif e attending ed for use as	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pregnancy			23d. Date of	
-	Ø 0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a 9□Unknown		Other (specify)			Month	Day Year
P.O.	that the de ted by the a detached f	Phy	9 Unknown					On Diller		
	ig.	by	Part II. Other significant condition	is contributing to death b	out not resulting in the t	inderlying cause give	эл іп Рап І.			e to the cause of death?
Records,	v requir baen s should	Completed	<del> </del>	<del></del>				1 L Yes	s 2   NO 3	Probably 4 Nonknown
ec	elaw hasb je2sh	ple						24a. Was an autopsy	prior	autopsy findings available to completion of cause of
<u>=</u>	The ate	Co						perform 1 Yes 2		
of Vital	Physicien: T r this certificat ral diractor, pa	Be	25. Was case referred to medical examiner?	14			26. Place of Death	(Check only one	)	19.34
7	Physic this c	၉	1 ☐ Yes 2 ☑ No	Hospital: 1  Inpatie		the state of the s	4 ☐ Nursing Ho		nce 6 Other (S	Specify)
ū	մing Physicien։ Դ. After this certific funaral diractor,	on:	27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time o ly Year) Injury	Work		28d. Describe how	w injury occurred	
sio		cati	2 ☐ Accident investign 3 ☐ Suicide 6 ☐ Could n	ot be			Yes 2 □No	00/ 1 11 /01		
Division	i Si the	Certification;	4 Homicide determine	and 200. Place of In	jury - At home, farm, st ic. (Specify)	reet, factory, office		City or Town,	eet and Number or State)	Rural Route Number,
	To the Hospital or Attentwithin 24 hours after deatl To tha Funeral Director: completely filled in by the			Physician: To the best						
	the Ho hin 24 tha Fu npletel	Medical	опе)	xaminer: On the basis o and manner st	ated.					
	To the within To that comple	-	29b. Signature and title of certifier	No		29c. License	ארא דא אייי	29	d. Date signed (M	опп, рау, төаг)
	2 M		Gofan) L.	(linean)	am,	100	56/16		5/31/0	04
			30. Name and address of person v	the completed cause of c	death (Item 23a) (Type MD 145	Print) E. CARI	2026 S	T SALI	SBYR-W.	MD. 21801
	Sta Registr		31. Date filed (Month, Day, Year) APR 0	1 2004 32. Regist	rar's Signature	& spon	K		1)	

State of Maryland / Department of Health and Mental Hygiene 2004 | 2882 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician John Marquis Vanderscoff 11:45 A M 28 2004 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Homewood Retirement Center Williamsport Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X) M 2□F Days Hours 017-01-4050 88 Director Feb. 17, 1916 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Exacut at must be multiled at Williamsport 1 ☐ Yes 2 X No Maryland Washington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Ave. Cottage 21 21795 USA or Items 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 □ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Government f Health and Mental Hygi item 27 is marked othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Charles Robert Vanderscoff Lelia Laural Reitzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 489 Flynn Drive Front Royal, Virginia 22630 Jan Ford/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 = 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 Denation 5 ☐ Other (Specify) Smithsburg Crematory 03-29-2004 Smithsburg, Maryland Signature Funeral/Service Dense 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** (4TERA Valresulting in death) /Medical Due to (c as a consequence of): Examiner O NOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 4□Pregnant at time of death 5 Other (specify) JYes 2□No P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting to the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ELAUNIC 1 Yes 2 No 3 Probably 4 Ninknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed! Yes 21 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending 1 Natural Injury death. within 24 hours after death.

To the Funaral Diractor: A completely filled in by the fu 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled le, death occurred at the time, date and the time, date and the cause(s) and manner stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) NEDICA MACON mpleted cause of death (Item 23a) (Type, Pripi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 12883 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 330 PM **Physician** DOROTHY PERRY VAUGHAN 2004 31 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 👿 F 77 1926 WASH.. 578-30-0103 Director Usual Residence of Decedent death with the Maryland 10d. Inside, City Limits 10c. City, Town or Location 10a. State 10b. County ral', or items 23s or 28s-f show Examiner must be notified at 1 Yes 2 No MD POOLESVILLE MONTGOMERY Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19570 FISHER AVE. 20837 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?/ 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) COURT CLERK LEGAL 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WARREN F. PERRY, SR. MARY ELIZABETH CHESTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SUSAN CAVELL / FRIEND 19574 FISHER AVE., POOLESVILLE, MD 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GATE OF HEAVEN 4/5/04 SILVER SPRING, \* 4 □Donation 5 □Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 20838 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) obstructive pulmonary disease Physician Years chronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ should be 1 XYes 3 Probably 4 Unknown 2 🗆 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 250 No 24a. Was an has page 2 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA Inpatient 1 Tes Certification: To this 27. Manner of Death filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 24 hours after deat 9 Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 1,2004 D59738 Mish 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive Rockville, MD 20850 5 9901 Mistry Hlicia 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

			For State Registrar			d / Depa		lealth ar	nd Mental Hy		2001	12884
			Decedent's Name (First, Middle, L.)	ast)			imouto or	D Gairr	2. Date of D	eath	,	3. Time of Death
	Physici /Medi		Carl Ce	dric Will	kerson,	Sr.			APRIL	Da	y Year	8.50AM
	Examir		4a. Facility Name (If not institution, g		-		4b. City, Town, o	r Location of I	Death	40	. County of Death	1
	-		Doctors Communit	·			Lanham				rince Geo	
- 1	Funeral Director		5. Social Security Number 6. 219-64-7903	Sex 7 1⊠M 2□F	7. Age (In yrs. la 46	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D	ay, Year)		place (State or Foreign ptry)
			Usual Residence of Decedent		70				0ct. 6	, 195	7 Maryl	and
. )	rylan thow	_	10a. State 10b. County			, Town or Lo					1	0d. Inside City Limits
3	88-fs	cto	Maryland Prince	George	Сар	itol H	leights					1X Yes 2 □ No
EDRIC	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Hauth and Mental Hygiene. Importent: if item 27 ie marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, if a Madical Examinal matable natified at once.	Completed by Funeral Director	10e. Street and Number 1805 Dewitt Aven	ue			10f. Zip Code	20743		_	tizen of What Cour ted State	•
(3)	death	nera	11. Marital Status	12. Was Deced	tent Ever in U.S	S. 13. \	Vas Decedent of H	lispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	0-	14. Race - Americ	
9	after or its	E.	1 ☐ Never Married 2 A Married	Armed Ford 1 Tes 2 If Yes, Give	No No		TYes, specify Cuba □ Yes 21X No		uerto Rican, etc.)		Black, White, Specify: Bla	
9/2 L 5-0036	ural',	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dat	tes:							
64 15	in 72 n "nat	ojete	15. Decedent's I (Specify only highest g	rade completed)		16a. Deced (Give life. L	ent's Usual Occup kind of work done OO NOT use retired	ation during most of d)	f working	16b. K	ind of Business/Ind	dustry
2121	d within giene. or than "	mo:	Elementary/Secondary (0-12)	College (1-	4or 5+)		k Clerk			Pr	ivate	
ੂ ਹ	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Las	•					Name (First, Middle		Sumame)	
$M_{LK} \epsilon_{\ell\ell} s^{O(2)}$ limore, Maryland	2 should be f and Mental H ie marked of raumatic eve	2	Charles G. Wilk			405 14 18			tte R. Si			
Mai	id 2 sh th and 27 ie n traun		19a. Informant's Name/Relationship Vickie E. Wilker		se				or Rural Route Numb pitol Hei			Code) )743
	s 1 and f Haalth item 27 other tr		20a. Method of Disposition	Bon, Bpou			sition (Name of natory or other place		Date		ocation - City or To	
W/Z	Pagas nent of I ont: if it		1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec		lale		natory or otner piac netery		:11 10,2004	Lot	thian, MI	).
$\mathcal{M}_{L\mathcal{K}}$ Baltimore,	permit. Paga Department of Importent: If eny injury or once.		21. Signature of Funeral Service Lice	ensee	201.0	A	. Name and Addres		Pope Fund	eral	Homes	
	8 9 E 9 9		was	-//	ikel				5538 Mar Forestvi	lle,	MD. 207	47
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	y one cause on ea	cn line.		er the mode of dyin	g, such as ca	rdiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	а	JANC		LAN	INGE	ial C	AN	CER	Ondo and Doan
	Examiner			Due to (o	r as a consequ	ence or):						
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (o.	r as a consequ	епсе оі):						
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.								
760,	ate be axecuted hysician and he burial-transit		resulting in death) Last	Due to (o	r as a conseque	ence of):						
	death certificate t attending physic of for use as the b	edicai		d								
Box 68	n certiful nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco							23d. Date of delive	rv
m.	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnai	th 2 □ Fetal on tat time of dea		Ectopic pregnancy Other (specify)					Day Year
P.O.	es that the death cer gned by the attendin be detached for use	Physician/Med	9 Unknown	9□ Unknov								
	ires th signed	by	Part II. Other significant conditions	contributing to dea	ith but not resul	lting in the ur	derlying cause give	en in Part I.		lobacco u Yes 2[	use contribute to th	e cause of death?
oro:	w requir	etec						_	-			
Rec	he law s has l ge 2 s	Completed							— 24a. Was auto	psy	prior to con	psy findings available appletion of cause of
ta	nn: Ti	e Co	25. Was case referred to medical					00 81		ormed? 2 No	1 ☐ Yes	2 □ No
<u> </u>	ysicie is cert direct	OB	examiner? 1 \( \sum \) Yes 2 \( \sum \) No	Hospital: 1 Xing	patient 2□E	R/Outpatien	3 DOA Othe	ner.	Death Check onl of ng Home 5 ☐ Resi		6 □Other (Specify	1
0	ng Ph ter th neral	n: T	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of (Month,		28b. Time of Injury	28c. Injun Worl	at at	28d. Describe			,
<u>si</u> 0	tendir eath. or: Al the fu	catic	2 Accident investigations in Suicide 6 Could not	on he			M 1 []	Yes 2 □ No				
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires that the death certificate be axeculed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	4 Homicide determine	286. Place o	of Injury - At hong, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location ( City or To	Street an wn, State	d Number or Rural )	Route Number,
_	spital		29a. Certifier 1 Certifying F	hysician: To the b	est of my know	ledge, death	occurred at the tim	ne, date and p	lace, and due to the	cause(s)	and manner as sta	ated.
	n 24 h	edical	(Check only 2 Medical Exa	miner: On the bas and manne	is of examination	on and/or inv	estigation, in my op	oinion, death o	occurred at the time,	date and	place, and due to	the cause(s)
	To the To the comp	M	29b. Signature and title of certifier				29c. License	-			e signed (Month, E	
	7		0					818	12	4-	-06-2	2004
2R	(4)		30. Name and address of person who Cecil D. George	completed cause	of death (Item :	23a) (Type, I	Print)	Gran	Lelt MA	2000	10	
M	Sta	te	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signatu	1	- Iar Kway	Tieer	belt MD.	×0.11		
11/1	Registr	ar	APR 0 8 2004	there)	15 A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 31, MARCH 2004 11:00 ₺ /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL TAKOMA PARK WASHINGTON ADVENTIST MONTGOMERY If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 6-14-1911 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F Months Days Hours GORDONVILLE, VA 579-18-6474 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiena. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or itema 23a or 28a-f ahov tre Medical Examinar must be notified at 1X Yes 2 □ No Director PG ADELPHI MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 8608 21st PLACE U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mentil. Pages 1 and 2 should be in Department of Health and Mental I importent: If item 27 is marked of BROOKS ELLA RAGLAND JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARROLL - GREAT NIECE 1232 CHILEAN TEAL TERR., UPPER MARLBORO, VICKI L. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ¶ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NAT'L 04 - 20 - 04ARLINGTON, VA TAYLOR'S FUNERAL HOME 21. Signature of Fundini Service 22. Name and Address of Facility 1722 NORTH CAPITOL ST., NW WASH.DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only doe cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy õ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 **17** No 3 Probably 4 Unknown page 2 should Completed peen 24a. Was an autopsy performer? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 Yes 1 TYes Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 20 Other: 4 Nursing Home 5 Residence 6 Other (Specify) No npatient Certification: To 1 Tyes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the Director: 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title o

DHMH 17 Rev 1/2001

Registrar

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31. Date filed (Month, Day, Year)

completed cause of death (Ifem 23a) (Type, Print)

45

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 11:55P M **Physician** Apri1 2004 Lucille Olga Watson /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) July 29, 1927 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days 1 ☐ M 2 ☑ F 76 Guyana 141-78-0006 Director Usual Residence of Decedent 10d. fnside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, it a Medical Examinar must be notified at 1X Yes 2 □ No MD Prince George Riverdale Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20737 U.S.A. 6307 63rd Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4or 5+) Hygiene. Housewife Domestic permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: if tem 27 1e marked other traumatic event, I.m. once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Randolph Jordan Matilda Wellington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Desiree Watson - Daughter Riverdale MD 20737 6307 63rd Place 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4/7/04 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityFort Lincoln Funeral Home 21. Signature of Funera 3401 Bladensburg Rd Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oxoseloutic **Physician** /Medical Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed ONNE that initiated events resulting in death) Last Box 68760, To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐ Pregnant at time of death 5 Other (specify) signed by the at d be detached for Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death bul not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes certificate Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: ↑ Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No in 24 hours after death.
the Funeral Director: After this c 2 ER/Outpatient 27. Many of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 ellely 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Takoma Park MD 7600 Carroll Avenue DOIS m COLEMAN 31. Date filed (Month, Day, Year) APR 0 6 2004 82. Registrar's Signature State Registrar

**ORIGINAL** 

		•	T= For State (Registrer	of Maryland		artment tificate			nd M		giene Reg. No. 2	004	12	888
	Physici		1. Decedent's Name (First, Middle, Last)  Augustine	Felix W	illian	ns				2. Date of De Month March	Day	Year 004	3. Time 1:50	of Death  A M
)	/Medic Examin		4a. Facility Name (If not institution, give street and n Forest Glen Skilled Nur Rehabilitation Center	umber) csing and	l			Location of			4c. Count	y of Deeth		
	Funeral Director		5. Social Security Number 579–38–1063 6. Sex 1 № 1 № 1 № 1	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da June 2	1, 1925	9. Birth Cou <b>Ma</b>	place (Stete intry) ryland	or Foreign
•	be filed within 72 hours after death with the Maryland ital Hygiene.  In the Medical Examination of the confiled at event, the Medical Examination of the confiled at	Funeral Director	1 Never Married 2 Married 1 M Yes	. W.  pedent Ever in U.S forces? 2 □No Feb.	. 13. v	10f. Zip C 2 Was Decede f Yes, specif	OO11 ont of His by Cubar	spanic Orig n, Mexican,	in? (Spe Puerto F	cify Yes or No Rican, etc.)	Bla	What Could Started Control of the Country of the Co	intry? tes ican Indian,	City Limits s 2 □ No
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e, Mai	is 1 and 2 should to the standard Health and Ment item 27 is marked other traumatic e		Roslyn Olivia Ricks Wil  20a. Method of Disposition	liams	5514	Secon	d St	reet,	N.W.		ington, D	. C.	20011	
Baltimore,	mit. Pages vartment of I cortant: If its injury or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	1 State		Natio	ona1	Memo	oril orial	3,2004 Park	Laurel	, Mai	ryland	
na	Depar Impor any irr		21. Signal of Funeral Service Licensee	2/		600 Ke	enne	dy St	reet	,N.W.;	ticians Washing	, Inc	.C.20	
/og/	Physician /Medical Examiner per partial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause Firster Inderthing Cause (Disease or injury that initiated events c.	caused the death. each line. to (or as a conseque	ance of):	MW.C	of dying	, such as c	ardiac of	r respiratory a	rrest,	S	Approxim Interval Be Onset and	etween
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ds, P.	uires that signed by d be deta	by	Part II. Other significant conditions contributing to	death but not result	ting in the ur	nderlying ca	use givei	n in Part I.			obacco use con Yes 2 <b>X</b> No			
II Hecords,	sician: The law requires that the certificate has been signed by the irector, page 2 should be detache	Completed	Perplant Va	u H	ears Dies	¥ £	Dise	lal	7	24a. Was autop perfo 1 🗆 Yes	psy prmed?	Were auto prior to co death? 1  Yes	opsy finding ompletion of 2 \( \text{No}	s available cause of
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Division	al or Attans s after death of Directors of in by the	Certification;	3 Suicide 6 Could not be determined buil	ce of Injury - At hom ding, etc. (Specify)	ne, larm, str	eet, factory,	office		2	Bf. Location (. City or To	Street and Num wn, State)	ber or Rur	al Route Nu	mber,
/	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Alter completely filled in by the fune	edical				vestigation, i	in my opi	inion, death			date and place,	and due t	o the cause	(s)
)	with To	M	29b. Signature and title of certifier	rkau n	m		Cicense O 6		4		29d. Date signe March			
	10		30. Name and address of person who completed ca  Myron L. Lenkin, M.D.;				ıd; I	Wheat	on,	Marylaı	nd 20902	2		
	Sta Registi	46	31. Date filed (Month, Day, Year) APR 0 5 2004	Registrar's Signaty	ire A	and i								

		For State	State of Mai	-	epartment of H Certificate of I			iene <sub>eg. No.</sub> 2001	12889
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Exami		4a. Facility Name (If not institution, give				r Location of Death		4c. County of Dea	
Funeral		Suburban Hospital  5. Social Security Number 6. Se		(In yrs. last birth	Bethesd		Date of Birth		thplace (State or Foreign buntry)
Director		127-14-8208	]M 2∏F	80 Y	Months Days			, 1923 New	
and *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town	or Location				10d. Inside City Limits
Maryli -f eho	to	Maryland Montgom	ery		Rockville				1 ☐ Yes 2X No
ith the Marylar or 28a-f ehow	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
ath wi	ral	1801 E. Jefferson			20852		fy Van as No	United St	
ire, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, tra Modical Examiliar Linest be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba	Specify:	can, etc.)	Black, Whi	
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/lan vuld be Menta arked artic ev	To B	J	ack Rothfe			Hannah			
Mary 12 sho h and 7 is m		19a. Informant's Name/Relationship (7 Alan Weinstein, Sc			Mailing Address <i>(Street</i> 24 Eastbour				
ore, M ss 1 and 2 of Health i item 27 i		20a. Method of Disposition			Disposition (Name of crematory or other place			20c. Location - City or	
Baltimore, bernit. Pages 1 at Department of Hea mportant: If item mportant: ortha	)	1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify			bron Cemete		04	Flushing,	Queens, NY
Baltimorr permit. Pages Department of It Important: If ite		21. Signature of Funeral Service Licen			22. Name and Addre	. Hobrott Eu	meral	Home, Inc.	20012
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused to one cause or each line	the death. Do no	ot enter the mode of dying	ng, such as cardiac or	respiratory arr	est,	20012 Approximate Interval Between Onset and Death
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/Medical Examiner			Due to (or as a	consequence of	D: C020	1. omeros	nalky		
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and I-trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence of	f):				
8760, cate be executed physician and the burial-transit	dical E		d						
<b>∞</b> a 4 ±		IF FEMALE:							
HHHH Goath certification of by the attending detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	y		23d. Date of de Month	livery Day Year
P. G. Hat III	y Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
Cords, wrequires to been signs should be							1 🗆 Y	es 2. VNo 3. P	robably 4 Unknown
Re e la has	Completed						24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of
	Be C	25. Was case referred to medical examiner?	11			26. Place of Death (	Check only or	10	/
of Vita Physician: this certific	<u>۲</u>	1 Yes 2 No	Hospital: 1 phpatier		patient 3 DOA			ence 6 Other (Spe	ecify)
un en grand an an an an an an an an an an an an an	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) In	jury Woi	rk?  Yes 2□No		. ,	
Meinstein  Division of N  To the Hospital or Attending Physi within 24 hours after death.  To the Funeral Director: After this of	ertification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, far . (Specify)	m, street, factory, office	28	Bf. Location (Si City or Town	treet and Number or F n, State)	lural Route Number,
Div Div To the Hospital or within 24 hours atte To the Funeral Dire	edical C			examination and	death occurred at the til Vor investigation, in my o				
To the within ,To the comple	Me	29b. Signature and title of certifier		. 1	29c. Licens		2	29d. Date signed (Mon	th, Day, Year)
		Megarely	man	/ "		27660		4/6/0	4
		30. Name and addless of person wind Alpana Goswami, M			le Pike #G	100, Rockvi	ille, M	D 20852	
S Regis	tate trar	31. Date filed (Month, Day, Year) APR 0 7 20	32. Registra	r's Signature	I Sparks				
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			Registrar  1. Decedent's Name (First, Middle, La	ast)		timouto or a		2. Date of Death		3. Time of Death
п	Physici /Medic		Margaret Eloise	Wheeler				April	Day Yeer 3 2004	11:45 P M
	Examin		4e. Facility Name (If not institution, gi			4b. City, Town, or	Location of Death	APLIL	4c. County of Dee	
	X.		Washington Adver			Takoma	Park		Montgome	ry
	Funeral		,	Sex 7. Ag 1 ☐ M 2 ☑ F	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Y		thplece (Stete or Foreign ountry)
	Director		387-09-5387 Usuel Residence of Decedent		90			Nov.10,1	913Wis	consin
	ryland how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	8e-f	Director	Maryland Montgon	nery	Germa					1 ☐ Yes 2 ☐ No
	with th		10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
	ne 23	eral	19056 Cherry Bend	Drive	Ever in U.S. 13.	2087 Was Decedent of Hi		ecity Yes or No-	USA 14 Race - Am	encan Indian.
(0	uriter d	by Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces?	No	Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	Black, Whi	te, elc.
8	rel', c	d by	3 ⅓Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
7	filed within 72 hours after death with the Maryland Hygiene. yther then "naturel", or Iteme 23e or 28e-f ehow ent, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gi	ducation rade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired,	ation during most of work	ing 16	b. Kind of Business	/Industry
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Maryland 21215-0036	Hygi other	Be Co	17. Father's Name (First, Middle, Las	t) 4	Sec	retary	18. Mother's Nam	e (First, Middle, Mai	ederal Go iden Sumame)	vernment
lan	Aenta Aenta rked ric ev	To B	Frank R. Froehli	ich			Hazel (	C. Wetlau	fer	
ary	and h		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a		a <i>l Route Number, C</i>		Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23e or 28e-1 show many injury or other traumatic event, the Medical Examinet must be notified at once.			Daughter		eil Road	Silver	Spring, Manager	aryland	20905
Baltimore,	O THE STATE OF THE		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 [		20b. Place of Dispo cemetery, crea St. Mark	natory or other place Eniscon	e) 21	Date 200	c. Location - City or	Town, State
量	rant Part Part Part Part Part Part Part Par		<ul><li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice</li></ul>		Cem	etery  Name and Addres	Apr.	7,2004 S	llver Spr	ing, Maryland
Ba	Department Department		AnneMari	etarker	Fr	ancis J.	Collins 1	Funeral Ho	ome, Inc.	
4	*		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. Do not ent	er the mode of dying	g, such as cardiac	.,W.,Silve or respiratory arrest	er Spring	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Acr	size b.	(1)	uma			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	0 1 16	Vacar	~~		( ) ) )
L	Examiner		Sequentially list conditions, if any, leading to immediate	b. — — — — — — — — — — — — — — — — — — —	a consequence of):					
	ted nsit	nine	Cause (Disease or injury	Due to (or as	a consequence or,					
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Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
P. O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at 9☐Unknown	time or death 5	Other (specify)				
S, P,	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	by Physiclan/Medl	Part II. Other significant conditions	contributing to death b	ul not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	w requires been sign should be	ed b	CUH	<u> </u>				1 ☐ Yes	2 ⊠No 3 □ P	robably 4 Unknown
ဝ၁	aw requast been 2 should	Completed	Dem	entia				24a. Was an		utopsy findings available completion of cause of
m m	The lay ate has page 2	Com						autopsy performed	death?	2 No
Division of Vital Record	vician: Th	Be	25. Was case referred to medical examiner?	Da - Pal		Tau		n (Check only one)	1	
of	Physi this c	. To	1 ☐ Yes 2 ☒ No  27. Manner of Death	Hospital: 1 🗷 Inpatie			4   Nursing Ho	me 5 Residence		cify)
o	ding h. h. After funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	Year) Injury	Work	r? Yes 2 □ No	20d. Describe flow	injury occurred	
N S	or Attenualter deatl	ifica	3 Suicide 6 Could not l	28e. Place of Inj	ury - At home, farm, str	eet, factory, office		28f. Location (Stree	t and Number or Re	ural Route Number,
	s after s after s Direct	Certification:	4 - Homicide	building, et	c. (Specify)			City or Town, S	iaie)	
	To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certiticate has completely tilled in by the funeral director, page 2	edical	(Check only 2 Medical Exa	hysicien: To the best	of my knowledge, death examination and/or in	occurred at the time	e, date and place, pinion, death occur	and due to the caus	e(s) and manner as	s stated.
	the the the the the the the the the the	Med	one) 29b. Signature and title of certifier)	and manner sta	ated.	29c. License			Date signed (Mont	
i			250. Signature and the control of	0	1 Sig	D	4566		4-4-	
	23		30. Name and address of person who	completed cause of d	eath (Item 23a) Type.	Print) Dpinde	, ,			
			14300	CALLA	WT fe	XCN	1, 1mg	15c	cien	1D 2e711
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 7 2	004 32. Registr	ar's Signature	South				

		í	For State Registrar	State of M		partment of ertificate o		d Mental Hygie	ne 2004 1289	-
•			Decedent's Name (First, Middle	e, Last)		<u> </u>		2. Date of Death Month	Day Year 3. Time of Death	
В.	Physici /Medic		John W. Winkl	er, Jr.				April 2,	2004 7:10 A	_
	Examin		4a. Fecility Name (If not institution	, give street and number	7)	4b. City, Town	, or Location of De	eath	4c. County of Death	
	Funeral		Washington Adv 5. Social Security Number	entist Hosp 6.Sex 7.A 1⊠M 2□F	ge (In yrs. last birthda	Months Day		Hrs. 8. Date of Birth (Month, Day, Yo	Montgomery  9. Birthplace (State or Foreigner)  Country)	n
79	Director		579-30-4123 Usual Residence of Decedent	102 M 20 F	76 Yrs.			July 16,1	927 Washington,DC	_
	and		10a. State 10b. County		10c. City, Town or	Location			10d. Inside City Limits	í
	Mary I-f sh	ţo	Maryland Prince	George's	Universi	ty Park			1 ☐ Yes 2 🙀 No	}
	with the Maryland a or 28a-f show Let notified at	Directo	10e. Street and Number			10f. Zip Code	•	10g.	. Citizen of What Country?	
	23a	al	6901 Forest Hil	l Drive		2078			USA	_
	terne	Funeral	11. Marital Status	12. Was Deceden		<ol> <li>Was Decedent of If Yes, specify Control</li> </ol>	of Hispanic Origin? uban, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
36	hours after death with the Maryland tural; or Items 23a or 28a-f show at Examble intust be inclifted at	by F	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates		1 ☐ Yes 2 🙀 N	lo Specify:		Specify: White	
21215-0036	2 hou		15. Deceden	t's Education	1936 16a. De	cedent's Usual Occ	cupation	161	b. Kind of Business/Industry	
212	within 72 ene. than "nai	pie	(Specify only higher Elementary/Secondary (0-12)	College (1-4o	r 5+)	ve kind of work dor a. DO NOT use ret	ne auring most of ired)	working		
	filed wit Hygiene Sther the	Completed		5+		ctor			edical	
_	o da da ya	Be	17. Father's Name (First, Middle,	Last)				Name (First, Middle, Mai		
<u> </u>	permit. Peges 1 and 2 should I Department of Health and Men mportant: If item 27 Ie marke nny injury or other traumatic ance.	2	John W. Winkle		10h 84	iling Address (Ctra		ia Edna Mull	Ligan ity or Town, State, Zip Code)	
Mai	d 2 sh h and 7 le m traun		19a. Informant's Name/Relations		2000	V.207 = 90076			1 1=5003E \$245.00E	
	1 and Health Iem 27		Suzanne Winkle 20a. Method of Disposition	r Wife	20h. Place of Dis	position (Name of		Ve Universi	Lev Park, MD 20782 c. Location - City or Town, State	_
و	Peges nent of ant: If it	- 5	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		arlingto	rematory or other p n Nationa	nlace)	- 11 2007		
altimore,	Department Department Important: I		21. Signature of Funeral Service		Cemet	22. Name and Add	dress of Facility		lington, Virginia	_
ñ	Ped Pine	7 1		Ble-		rancis J. 500 Unive	. Collins ersity Bl	s Funeral Ho	ome, Inc. ver Spring MD 20901	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	the death. Do not	enter the mode of d	tying, such as care	diac or respiratory arrest,	Approximate Interval Between	
8	nysician	0	Immediate Cause (Final disease or condition	Res	TAICTIVE	PUUMDA	924 215E	RE	Onset and Death	
	/Medical		resulting in death)	Due to (or a	s a consequence of):		J			
15	Examiner		Sequentially list conditions,	b. <u>SC</u>	DUIDSIS					_
	ed isit	ine	cause. Enter Underlying Cause (Disease or injury	Das to (or a	is a consequence of).					
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):					
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	tificat ig phy as the	= 1								
Вох	death certifica e attending ph id for use as th	M/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		3 □Ectopic pregna	ncv		23d. Date of delivery  Month Day Year	
	of the death certifica by the attending phateched for use as the	Physician/Med	in the past 12 months? 1 Yes 2 No			5 Other (specify)			Month Day Year	
o.	The law requires thet the ate has been signed by th page 2 should be detache	Phy	9 Unknown  Part II. Other significant condition	one contributing to death	but not resulting in the	underhing cause	given in Part I	23e. Did tobac	co use contribute to the cause of death?	
Records,	ires thei signed t	Completed by	PNOVMONIA	ons contributing to death	but not resulting in the	s underlying cause	given in a dict.		2 No 3 Probably 4 Munknowr	1
Ö	w require been sign should b	etec	1	511.100				24a. Was an	24b. Were autopsy findings available	
Re	has be 2	ig I	KESFIN WILLY FI	gilvre				<ul> <li>autopsy</li> <li>performed</li> </ul>	prior to completion of cause of death?	•
a	iclan: The l certificate ha rector, page	ပို	25. Was case referred to medica				26 Place of I	1 ¥ Yes 2 □ Death (Check only one)	No 1 ☐ Yes 2 ☐ No	_
5	Attending Physician: r death. ector: After this certific by the funeral director.	0 0	examiner? 1 Tes 2 No	Hospital: 1 XInpa	tient 2 ER/Outpa	tient 3 DOA	Other	g Home 5 Residenc	e 6 (Other (Specify)	
0	g Phy ler thi	T iu	27. Manner of Death	28a. Date of in		of 28c. In	njury at Vork?	28d. Describe how		
Ö	ath. parth. pr: Aft	atio	1 Natural 5 Pendir 2 Accident investi	gation	, , , , , , , , , , , , , , , , ,		□Yes 2□No			
Division of Vital	l or Atte after de Directo	Certification;	3 Suicide 6 Could 4 Homicide determ	ined 289. Place of I	njury - At home, farm, etc. (Specify)	street, factory, office	Ce C	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)	
	To the Hospital or Attending Phyminic 24 hours after death.  To the Funerel Director: After to completely filled in by the funeral	edical C			of examination and/or				ee(s) and manner as stated. and place, and due to the cause(s)	
	Nithin No the	Me	29b. Signature and title of certifie	Milah		29c. Lice	ense number	29d.	Date signed (Month, Day, Year)	
	15+1			SHEET?		D 5	0791		4/3/04	
			30. Name and address of person	who completed cause of	death (Item 23a) (Type				1//	
			Damirez Fosset			Park Dri	ve Silv	er Spring,M	aryland 20902	_
	Sta Registi		31. Date filed (Month, Day, Year, APR 0 7	32. Regis	strar's Signature	Space				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4

Certificate of Death 12892

	港	1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea	Reg. No.		3. Time of Death	
hysicia /Medica		Madeli	ne Le	e Winne			March 2	Day	4 Year	6:02 P. M	J
xamine	er	4a. Facility Name (If not institution, giv	,		4b. City, Town, o	or Location of Dear			nty of Death		-
		Washington Advent	-		Takoma				gomer	У	
neral ector		377-12-1473	1 M 2 X F	e (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days			, Year) 1918	9. Birth Cou Idah	place (State or Foreign intry)	7
A		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation					10d Ignido City Limite	_
notified at	ğ	MD. Montgomen	rv	Silver Sp						10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
notili	iec	10e. Street and Number	- )	DILVET DP	10f. Zip Code			10g. Citizen o	f What Cou		-,
238 0	a D	15310 Pine Orcha	rd Dr. #2A		20906			USA		,	
d other than "natural", or Items 23a or event, the Medical Examinat must be	by Funeral Director	11. Marital Status	12. Was Decedent I		Was Decedent of H	lispanic Origin? (S	Specify Yes or No-	14. Ra		ican Indian,	-
arriko	Y Fu	1 Never Married 2 Married	1 Pyes 2 N	10 MMTT	1 ☐ Yes 2 🖾 No		to rican, etc.)		ack, White		
alEx		3 XWidowed 4 Divorced	Year or Dates:						<i>™</i> Whi		_
Special	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	pation during most of word)	rking	16b. Kind of	Business/Ir	ndustry	
E ST	E	Elementary/Secondary (0-12)	College (1-4or 5	Teacl		-/		Educat	ion		
vent,	Be C	17. Father's Name (First, Middle, Last)		1 20001		18. Mother's Nar	me (First, Middle,				-
atic	0	William E. Lee				Mary Ma	deline S	heilds			
E E		19a. Informant's Name/Relationship (			ng Address (Street						_
har ti	-		ne/Son				NAME OF TAXABLE PARTY.			, MD. 2090	E
do		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other plac	ce)	Date	20c. Location	- City or To	own, State	
o iery	1	' 4 □ Donation 5 □ Other (Specify		Mt.Comfort	t Cremato	ry 4/2/	2004	Alexan	dria,	Va.	
any njury or other traumatic	4	21. Signature of Funeral Service Licen	1500							Inc., 5130	
_	-	2000	7	WIS	sc. Ave.,		COINCEAN	11 1	/111116		
100		23a, Part 1, Enter the disease, or com-	nlications that caused						20010	A	-
		23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not ente	er the mode of dyin	g, such as cardiac			20010	Approximate Interval Between Onset and Death	_
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State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year) APR 05 2004

Sporker

		ıf	For State Registrar	State of I	Maryland /		artmen rtificate					giene Reg. No. 2	04	2893
	Physicia /Medic	in al	1. Decedent's Name (First, Middle RICHARD	THOMAS	WIDGEON	J	SR On	Tour or	Location		2. Date of Dea Month MARCH 2	Day	Year	9:25 p <sup>M</sup>
	Examin	-1	4a. Facility Name (If not institution, 26684 Villaged 5. Social Security Number	dale Place	ar) Age (In yrs. last i	oirthday)	A1	len 1 Year	If Under	24 Hrs.	8. Date of Birti	Wico	mico	e (State or Foreign
	Funeral Director		214-42-8418 Usual Residence of Decedent	1 <b>⊠</b> M 2□ F	59	Yrs.	Months	Days	Hours	Min.	May 8,		Mary]	
	the Marylar 28a-f show	_	10a. State 10b. County  Maryland Wicon  10e. Street and Number	nico	A1		10f. Zip	Code				10g. Citizen of \		1 ☐ Yes 2 ☐ No
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. A critical of Health and Mental Hygiene. Totant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Example or must be notified at injury or other traumatic event, the Medical Example or must be notified at 9.	by Funeral	26684 Villac  11. Marital Status  1 □ Never Married 2 → Marri 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 X Yes 2	nt Ever in U.S. es? □ No		Was Deced It Yes, spec				ecify Yes or No- Rican, etc.)	USA 14. Rac Btac Specify	ee - American ck, White, etc.	
21215-0036	l within 72 ho iene. r then "natur the Medical.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		or 5+)	(Give life.	dent's Usua kind of wor DO NOT us	rk done d se retired	du <i>ring</i> mos )			16b. Kind of B		
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	1 and 2 sho Health and I em 27 Is me ther traume		19a. Informant's Name/Relationsh Sharlene A. Will 20a. Method of Disposition			26	684 V:	illa	gedal	e Pl	al Route Numbe ace, Al	•	21810	
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 Burial 2 Tornation 4 Donation 5 Other (Sec. 21. Signature of Funeral Service I	ecify)	118	bur	y Crei	mato	ry	tv	05/2004 ome_Pro	Salisb	ury, M	
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<u>α</u>	w requires that the de been signed by the a should be detached f	þ	Part II. Other significent condition	ns contributing to deat	h but not resulting	g in the u	underlying c	ause give	en in Part I		1 🗆 Y		3 Probably	y 4 ⊡Unknown
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ion of Vit	ding Phys I. After this funeral di	ation: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Actival 5 Pendin investig	28a. Date of (Month,	atient 2 ER/d Injury Day Year) 28t	Outpatie Time of Injury		8c. Injun Worl	er: 4 🗆 Nu	ırsing Ho	me 5 Residence only on the second of the sec	lence 6 □Oth		
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: Completely filled in by the	Certification;	3 Suicide 6 Could r 4 Homicide determ	ined 286. Place of building	tnjury - At home, , etc. (Specify)						28t. Location (S City or Ton	m, State)		
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	2 1 2 5 5 t Wit		30-Name and address of person	- >	pt death (Item 23)	a) (Type	Print)	) 60	021	/		04/0	1/20	004
	Sta Registi		81. Date filed (Month, Day, Year) APR 0 5	32. Beg	jistrar's Signature	4	J. 15	20.	A) h	A	1, 5A	LTIM	ORE	M) ZR3

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** WEBER NELSON 7:00 AM APRIL 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20 NEWPORT DRIVE BERLIN WORCESTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 XM 2 □ F Yrs. Director 202-24-1791 73 27, 1931 PENNSÝLVANIA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be marified as once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MARYLAND WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 NEWPORT DRIVE 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ሺ Yes 2 □ No If Yes, Give Year or Dates: VIETNAM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 SR. MASTER SGT. AIR FORCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NELSON WEBER EVELYN DORSCHIMER ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN N. WEBER/WIFE 20 NEWPORT DRIVE, BERLIN, MARYLAND 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 4/5/04 DELMAR, DELAWARE ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 s 24a. Was an autopsy performed 2 🗆 No 1 Yes 2 No 1 TYAS Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Yeer) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a
To the Funeral L
completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P0056776 Salery unlar MO 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) CARROLL ST SALISBURY, M 21801 SON 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 0 6 2004 State Registrar

			1 - For State Registrar	State of Marylan				and M				12895
	Physici /Medi	al	Decedent's Name (First, Middle, Last     Charles Willia	m York, Sr.					2. Date of Dea Month March	Day	Year 2004	3. Time of Death 8:10 PM
	Examir Funeral	er	4a. Facility Name (If not institution, give Washington Coun  5. Social Security Number 6. Sec	ty Hospital x 7. Age (In yrs.	last birthday)	4b. City, To	wn, or Location of Hagers	town		4c. Count	Was	hington
	Director	200	244-40-1588  Usual Residence of Decedent  10a. State  10b. County	XM 2□F 7.			Pays Hours	Min.	8. Date of Birth (Month, Day May 12,	1930		ace (State or Foreign h) Carolina
	th the Maryli or 28a-f eho e notified	Irector	Maryland Washin			agersto			1	log. Citizen of		d. Inside City Limits  1 Yes 2 No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, in a Muulcal Evaritiver must be notitied at once.	Completed by Funeral Director	11213 Piper Lane  11. Marital Status  1 Never Married 2 Married 3 Never Married 4 Divorced	12. Was Decedent Ever in U Armed Forces? 195 1 ZYes 2 □ No If Yes, Give Year or Dates: 195	4- "	Vas Decedent Yes, specify	t of Hispanic Orig Cuban, Mexican	gin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)		ce - America ck, White, et	tc.
Maryland 21215-0036	ed within 72 hou /giene. er than "nature i. the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give :	lent's Usual O kind of work d DO NOT use n	lone during most etired)	t of workii	ng	16b. Kind of B		·
ryland	hould be fill d Mental Hy marked oth matic eveni	To Be	17. Father's Name (First, Middle, Last)  Haskell  19a. Informant's Name/Relationship (Ty	York	40h A4-17-	A 11 (O)	Alma	L	(First, Middle, I			
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Balti	permit. Departm Importe any nju		21. Signatura of Funeral Service License	Ded.	03	sborne <sup>A</sup>	Feneral Conococh	Hom	e,P.A.	100		
8760,	The law requires that the death certificate be executed  HAS been signed by the attending physician and  age 2 should be detached for use as the burial-transit	dical Examiner	23a. Part f. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).	uence of):		by hu				1 6	Approximate nterval Between Onset and Death 2 horro
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	n: The law r cate has be r, page 2 sh	Completed							24a. Was ar autopsy perform 1 Yes 2	ned?	Vere autopsy prior to comp leath?	y findings available letion of cause of
Division of Vital	ttending Physicien: The la death. ctor: After this certificate ha. y the funeral director, page 2	10 B	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 I E	ER/Outpatient 28b. Time of Injury	28C. I	26. Place of Other: 4 \(\text{\tint{\text{\tint{\text{\te}\text{\texi}\text{\text{\texi{\text{\texi{\texi{\texi{\texi{\texi{\texi{\texit{\tet{\text{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\t	sing Hom 28	(Check only one e 5  Resider 3d. Describe how	nce 6 Othe	er (Specify) ed	
Divis	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,	")				Bf. Location (Str. City or Town,	State)		
	the Hosp thin 24 hou the Fune mpletely fil	Medical	29a. Certifier (Check only one)  1☐ Certifying Phys 2☐ Medical Examin 29b. Signature and title of certifier	ician: To the best of my knowner: On the basis of examination and manner stated.	wledge, death ion and/or inve	stigation, in n	ny opinion, death	place, ar occurred	at the time, da	te and place, a	ind due to the	e cause(s)
	48		michael of	The Land	23a) (Tuna B	1	ense number	7		d. Date signed	8.04	
	Stat		Michael Mcc 31. Date filed (Month, Day, Year)	mpleted cause of death (Item	UILO N	redsed	lingo	. 1	1. Be	serobu	n MA	2
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			For State Registrar	State of Ma	•	epartmen Certificat				giene Reg. No. 2	001	s 10	2804	
	Physici /Medic		Decedent's Name (First, Middle, Last)     WALTER JOHN	ZOLKIEWI	CZ					2, Day 004	Year	3. Time of 7:20	Death A M	
	Examin	_	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery			
のから	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  Integrated the filem 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Maurical Extrating or institute at once.	To Be Completed by Funeral Director	5. Social Security Number 147-32-2251 6. Sex 1 2 Usual Residence of Decedent	M 2 F	(In yrs. last birth	Months	1 Year Days	If Under 24 H Hours M	in. 8. Date of Birt (Month, Da Nov • 30	1942	Cou	olace (State ontry) Jersey	-	
Baltimore, Maryland 21215-0036			10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits  Md. Montgomery Gaithersburg 1 □ Yes 2 🖫 No.											
			10e. Street and Number  13 Joshua Tree Court  10f. Zip Code					878		10g. Citizen of United		•		
			11. Maritat Status  1 Never Married 2 Married 3 Widowed 4 Divorced	ver in U.S.  13. Was Decedent of If Yes, specify Ct  1 □ Yes 2 ▼ N			panic Origin? , Mexican, Pu Specify:	14. Ra Bla	14. Race - American Indian, Black, White, etc.  Specify: White					
			15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   Contracts Administrator							16b. Kind of Business/Industry  Federal Contracting				
	ould be filed Mental Hygi arked other atic event, I		17. Father's Name (First, Middle, Last)						Name (First, Middle, Maiden Sumame)					
	nd 2 sho lith and 27 is m r traum		19a. Informant's Name/Relationship (Type Barbara Zolkiewicz	•		1.7			Gaithers					
	permit. Pages 1 as Department of Heal Important: If item eny injury or other once.		20a. Method of Disposition  1 M Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)	emoval from State	20b. Place of D	Disposition (Name of crematory or o	ne of ther place	Ap	Date	20c. Location Germant	- City or To	own, State		
			21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877									377		
Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit entry.	Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications (fat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Improximate Interval Between Conset and Death disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):							ween Death				
			d.											
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   No Section   Vestion   Vestion   No Section   Vestion   No Section   No Section   No Section   Vestion   No Section   No							23d. Date of delivery Month Day Year				
			Part it. Other significant conditions contributing to death out not resulting in the onderlying cause given in Part it.											
										med? 2 No	death?	psy findings impletion of c	available ause of	
		tlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death 1 Adural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury				26. Place of Death (Check only Other: 4 Nursing Home 5 Res nury at Work? 1 Yes 2 No						
Divisi		ledical Certification;	3 Suicide 6 Could not be 4 Homicide determined	OB Class of lawn. At home form street feeters office					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
													)	
)	within To the Comp	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  VELSON KALIL, MD (BIII Prince Philip Drive, #327, Olney, MD 26832  31. Date filed (Month, Day, Year)  32. Registrar's Signature											
			30. Name and address of person who con NELSON KAL	IL, MD	ath (Item 23a) (T	Prince (	hil;	p Dri	ve,#3.	17,01,	vey	MD 20	832	
	Sta • Regist		APR 0 6 200	32. Registrar	's Signature	9 Soi	nen	, ,						

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	State of Maryland	Certificate of Death	Reg. No. 200	4 1289
Dhysisian	1. Decedent's Name (First, Middle, Last)		Dete of Death     Month Day Year	3. Time of Death
Physician /Medical	Arden A. Andreae		April 22 2004	11:55 PM
Examiner	4a Fecility Name (If not institution, give street end number)	4b. City, Town, or Lo		
	Pickersgill	Towson	Baltimo	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. les 88 Usuel Residence of Decedent	st birthday) Yrs.  If Under 1 Year  If Under 24 Hrs.  Months  Days  Hours  Min.	8. Date of Birth (Month, Day, Yeer) 9. Birch Sept. 3, 1915 In	inthplace (State or Foreign Country) Idiana
pu ≱ ■		Town or Location		10d. Inside City Limits
h the Marylen or 28e-f ahow nothed	Md. Baltimore Tows	on		1 ☐ Yes 2X No
the rec	10e. Street end Number	10f. Zip Code	10g. Citizen of What C	Country?
th with 23a or ust be	115 Greenbrier Rd.	21286	ι	JSA
urs efter dea sir, or items sant ner m by Funer	11. Manital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 X Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispenic Origin? (Sp If Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No- Rican, etc.)  14. Race - Am Black, Wh	
ed within 72 hours ygiene. ••• than "natural", rt, the Modical Ex Completed by		16e. Decedent's Usual Occupation	16b. Kind of Busines	s/Industry
a - 3	(Specify only highest grede completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16e. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)		
nd 2 should be flied within the and Mental Hygiene. 27 Is marked other than traumatic event, the M	+4	Asst. Treasurer	Telephone	Co.
should be flied within and Mental Hygiene. I marked other than umatic event, the M	17. Fether's Name (First, Middle, Last)		e (First, Middle, Maiden Sumame)	
Ment Ment Ment Ment Ment Ment Ment Ment	Clarence Andreae	Winifre		
s 1 end 2 should f Health end Mer Item 27 la marke other traumatic	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run		, Zip Code)
end eaith n 27	Mrs. Nancy A. Andrew/ Daughter	115 Greenbrier Rd. To		- T C4-4-
Φ O == ==	1 Buriel 2X Cremation 3 Removal from State 4 Donetion 5 Other (Specify)	top Service Co.	Date 20c. Location - City of Towson, M	
permit. Peg Depertment Important: I any Injury o	21. Signature of Funeral Service Licensee	Ruck Towson Funera 1050 York Rd. Tows	on, Md. 21204	
Physician /Medical Fxaminer	23a. Part 1. Enter the disease, of complications that caused the death. shock, or heart failur. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	Do not enter the mode of dying, such as cardiac  ESEPSES SYND  as a consequence of):		Approximate Interval Between Onset and Death
law requires that the death certificate be executed es been signed by the ettending physician end a 2 should be deteched for use as the buriel-transit npleted by Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury c.	es e consequence of):		
death d for	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23b. Did tobacco use contribu	te to the cause of deat
v requires that the death certive been signed by the ettending should be deteched for use efeted by Physician/M	chronic obstructive	1	1 □ Yes 2X No 3 □	Probably 4 Unknown
The law requires the cate has been signe page 2 should be completed by			24a. Was an autopsy performed?	. Were autopsy finding available prior to completion of cause of death?
a E & E			1 □ Ves 2 No	1 ☐ Yes 2 ☐ No
delan: The certificate rector, pag	25. Was case referred to medical	26. Place of Deat	h (Check only one)	
hysician: his certification di director,	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 E	R/Outpatient 3□ DOA Other: 4x Nursing Ho	ome 5 Residence 6 Other (Sp	ecify)
After the funeral	1 X Naturel 5 ☐ Pending (Month, Dey Year) 2 ☐ Accident investigation	28b. Time of Injury at Work?  M 28c. Injury at Work?  1  Yes 2 No	28d. Describe how injury occurred	
tal or Attending P rs efter death. al Director: After ti led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (Street and Number or I City or Town, State)	Rural Route Number,
Hospi 4 hou Funer tely fil	one) and manner stated.	on end/or investigation, in my opinion, death occur	red at the time, date and place, and de	ue to the cause(s)
To the To the Comple	29b. Signature and title of certifier  Holy Mules	$\frac{29c. \text{ License number}}{2525205}$	29d. Date signed (Mo)	nth, Day, Year) 23, 2004
6+1	30. Name end address of person who completed cause of deeth them 2	38) (Type, Print) 678 (N. Chali St.	Balko md 2	1204
State Registrar	31. Date filed (Month, Day, Year) 32. Registrer's Signatu	& Sports		

			For State Registrar	ate of Maryland / Dep Co	partment of Heartificate of I			iene 2004	12898
	Physici	an	Decedent's Name (First, Middle, Last)	Deterision Amm Bi	a1 av		2. Date of Death Month April 2	h	
	/Medic	al	4a. Facility Name (If not institution, give street	Patricia Ann Bi		r Location of Death	APITI Z	4c. County of De	3.23
	Examin	er	7873 Americana Circl		Glen Bur			Anne Ar	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	inthplace (State or Foreign Country)
	Director		220-36-1937 1 M 2	64 Yrs.	, , , , , , , , , , , , , , , , , , ,		Oct 6,	1939 We	st Virginia
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	Maryl -f sho	ţō	MD Anne Arunde	1 Glen Bu	rnie				1 X Yes 2 ☐ No
	death with the Maryland ms 23a or 28a-1 show	Director	10e. Street and Number		10f. Zip Code		10	0g. Citizen of What 0	Country?
	23a c		7873 Americana Circl	e T-2	21060			U.S.A.	
	tams	Funerai	Ar Ar	med Forces?	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
9	be filed within 72 hours after death with the Marylan lal Hygiene. d other than "natural", or items 23s or 28s-f show avent, the Medical Exame incrines be notified at	by F	_ T	☐Yes 2 🔯 No Yes, Give ear or Dates:	1 ☐ Yes 2 💢 No	Specify:		Specify: Wh	ite
ş	2 hou	ted	15. Decedent's Education	16a. Dec	cedent's Usual Occup			16b. Kind of Busines	s/Industry
2 2	e. an n	Completed	(Specify only highest grade com Elementary/Secondary (0-12)	bilege (1-4or 5+)	ve kind of work done of DO NOT use retired	during most or work.	- 1	Motor Veh	
7	ygien ygien ner th		12	Pho	tographer	18. Mother's Name		Administra	ation
and	ould be fi Mental H arked otl atic sver	Be	17. Father's Name (First, Middle, Last)  John Harvey Caves			Nora Rey		naioen Sumame)	
Maryland 21215-0036	as 1 and 2 should be of Health and Menta of Health and Menta litem 27 is marked rother traumatic so	ြင	19a. Informant's Name/Relationship (Type, Pr	int) 19b. Ma	iling Address (Street			City or Town, State,	Zip Code)
-	and 2 sealth ar n 27 is		Gerald P. Bigley /s	pouse 787	3 American	na Circle	T-2, G1	en Burnie,	MD 21060
ğ.	of Head		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remov	cemetery co	position (Name of rematory or other place		Date 2	20c. Location - City of	r Town, State
Ĕ	Pages ment of ant: If it ury or o		* 4 □ Donation 5 □ Other (Specify)	W. Aruno	lel Cremat			Odenton, N	
Baltimore,	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Lionn se	M00773	<sup>22. Name and Addres</sup> Donaldson 1411 Annap	ss of Facility Funeral H oolis Road	Home & Ci	rematory, on, Marvla	P.A. and 21113
	q		23a. Part1. Enter the disease, or complication shock, or hear failure. List only one cau	s that caused the death. Do not e					Approximate Interval Between
	Physician	8.7	Immediate Cause (Final disease or condition	HRONLC O	BSTRUC	TIVE F	GLMON	ARY Dis	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	<b>2</b> 7	92		(-	
V		-e	Sequentially list conditions, b.	Dua to (or as a consequence of):					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
o,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Еха		Due to (or as a consequence of):					
8760	ate be hysici	dicai	d						
Õ	ertific ding p	/Mec	IF FEMALE:	yes, outcome of pregnancy				001 0-1-11	
Вох	leath certific attending p	Physician/Me	in the past 12 months?	Live birth 2 Fetal death 3	Ectopic pregnancy			23d. Date of de Month	Day Year
o.	the de y the ached	ysic		Unknown					
יט מי	w requires that the d been signed by the should be detached	by PI	Part II. Other significant conditions contribut		underlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ğ	en sig	led t	CORONARY AR	TERY DISTA	55		1 🗆 Ye	s 2 □ No 3 1 PF	robably 4 Unknown
Records,	e law re has be ge 2 sho	Completed					24a. Was ar autopsy	prior to	utopsy findings available completion of cause of
		Соп					perform 1 Yes 2	ed? death? No 1 ☐ Ye	
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	alt.	Othe	26. Place of Death			50.
	this aldi	.: To	TU Yes 200 NO	a. Date of Injury 28b. Time	of 28c. Injury	y at	me 5 Feside 28d. Describe ho		ecify)
on	nding th. r: Afte e fune	atior	1 ANatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury		k? Yes 2 □ No			
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific: completely filled in by the funeral director.	Certification:	a □ a : : t	Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Str City or Town,	eet and Number or F State)	Rural Route Number,
	pitef ours a lerei C		29a. Certifier 1 Certifying Physician	: To the best of my knowledge, de	ath occurred at the tim	ne, date and place.	and due to the ca	use(s) and manner a	s stated
	e Hos 24 h Fur letely	Medicai	(Check only 2 Medical Exeminer: C	In the basis of examination and/or and manner stated.					
	To th To th comp	M	29b. Signature and title of certifier	-01)	29c. License			d. Date signed (Mor.	
)	3		> Muhad Z	NAD	Do	2514	/	APRIL 2	23 2004
_			30. Name and address of person who completed	ed cause of death (Item 23a) (Typ	Print) CRAI	N TOWE	RE, GI	EN BURI	23 2004 NE, MD.
9	Sta Registi		31. Date filed (Month, Day, Year) APR 2 6 2004	32. Registrar's Signature	Sparks				·

			State of Maryland / Department of Health and Mental Hygiene  1- For State of Maryland / Department of Health and Mental Hygiene Registrar AMPND TIFM #20a-c PER FH C830 4/26/04 TIFF Cate of Death  Reg. No. 2004   289
	Physic		1. Decedent's Name (First, Middle, Last)  RICHARD C. BARCLAY  2. Date of Death Month Day Year APRIL 10 2004 9:30 AM
7	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RIVERDALE PRINCE GEORGE'S
ļ	Funeral Director		5. Social Security Number 083-36-8383 6. Sex 12 M 2 F 97 Yrs. 1ft Under 1 Year If Under 1 Year If Under 24 Hrs. Months Days Hours Min. August 13 1906 Rhode Island
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, if a Medical Examinational Department of DDCs.	To Be Completed by Funeral Director	10b. County   10c. City, Town or Location   10d. Inside City Limits   1
Baltii	permit. F Departme importar eny injur		21. Signature of Funeral Service Licensee  22. Name and Address of Facility J. B. Jenkins Funeral Home  7474 Landover Road Landover, Maryland 20785
760,	Physician /Medical Examiner paper support of the prigation and paper support of the prigation of the prigation of the prigation of the prigation of the prigation of the price	ical Examiner	23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  End Stage Dementia  a. End Stage Dementia  Due to (or as a consequence of):  Hypertensive Cardiovascular Disease  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):
.O. Box 68	death certifica e attending ph id for use as ti	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
ords, P	The law requires that the ste has been signed by th bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 XIUnknown
al Records,		Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No
Division of Vital	ttending Phys death. stor: After this the funeral di	Certification; To Be	25. Was case referred to medical examiner?  1
ā	Hospita 4 hours Funeral ely fillec	edical Cert	29a. Certifier  (Check only one)  1 **X**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 **Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the To the Complete	Me	29b. Signature and title of ceptilier  29c. License number  29d. Date signed (Month, Day, Year)  H-12-04
0.	Sta Registr	- X	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Neelam Ashai, M.D. 4410 74th Avenue Landover Hills, Maryland 20784  31. Date filed (Month, Day, Year)  APR 2 6 2004  Server Signature

			For State Registrar	State of I	Maryland / Dep Ce	artment of F	lealth and Death		iene200	12900
	43		Decedent's Name (First, Middle	e, Last)				2. Date of Dea	th	3. Time of Death
М	Physici		Marian	Cope	Ben	field		April	Day Yea 20	I TOO M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and numbe		4b. City, Town, o	or Location of De		4c. County of D	
	LAGITILI	C.	Anne Arundel 1	Medical Cen	ter	Annapo1	is		Anne Arı	ınde1
- 2	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday)		If Under 24 I	Hrs. 8. Date of Birth		Birthplace (State or Foreign Country)
	Director		230-32-2984	1 □ M 2 🔭	77 Yrs.	Mortus	110013	Aug. 27	1926 V:	irginia
	, nd		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	noation				10d. Inside City Limits
	anyla shov	7		Arundel						11√2 Yes 2 □ No
	28s-f	Director	10e. Street and Number	Arunder	Annapo	10f. Zip Code			0g. Citizen of What	
	a or	급	35 Milkshake La	•						Oddiniy i
	eath	era	11. Marital Status	12 Was Decede	nt Ever in U.S. 13.		403 Hispanic Origin?	? (Specify Yes or No-	USA 14. Race - A	merican Indian,
	titen riten	Funeral	1 Never Married 2 Marri	Armed Force				? (Specify Yes or No- uerto Rican, etc.)	Black, W	hite, etc.
99	urs a	þ	3 ☐ Widowed 4XX Divorced	If Vas GNA	-	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "cetural", or items 23e or 28e-f show the Macical Examirer must be notified at	Completed		it's Education st grade completed)		dent's Usual Occup		working	16b. Kind of Busine	ss/industry
7	thin 7	nple	Elementary/Secondary (0-12)	College (1-4d	life.	DO NOT use retire	d)			
7	ed wi	Co	12		Nursi	ing Assis			Nursing S	Service
p	d oth	Be	17. Father's Name (First, Middle,	Last)				Name (First, Middle, I	Maiden Sumame)	
<u>X</u>	Men	၉	George West					a Beavers		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-1 show says injury or other traumatic event, the Macical Examiner must be notified at once.	1	19a. Informant's Name/Relations					r Rural Route Number		e, Zip Code)
6	and fealth m 27 her t		Linda J. Thomas	(Daughter	) 141 20b. Place of Disp		Lothia	n, MD_2071	1 20c. Location - City	or Town State
Baltimore,	ges it of h if its or of		20a. Method of Disposition  XXBurial 2 ☐ Cremation		te cemetery, cre	matory or other pla	1		•	
ij	tmen tant:		`4 □Donation 5 □Other (S			en Cemet		/27/2004	Glen Burn	ie, MD
Bal	Deparenti Deparenti Importanti Eny ir		21. Signature of Funeral Service	Licensee	//     2	2. Name and Addre Hardesty	Funera	l Home, P. ue, Annapo	A.	
ų.	401 * 4		23a, Part1, Enter the disease, or	Samplinations that cause	red the death. Do not on					1401 Approximate
			shock, or heart failure. List			0	_	orac or respiratory arm	631,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		rumo	nia			1 deg
	Examiner			Due to (or	as a consequence of):					,
		P.	Sequentially list conditions,	b. — Due to (or	as a consumence of:					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b>						
Ć	exec in an	Exa	resulting in death) Last	c. Due to (or	as a consequence of):					
8760,	icate be executed physician and s the burial-transit			d						
9	certificate be executed nding physician and use as the burial-transit	Physician/Medical								
Вох	eath certif attending for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth		□Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
	O O	sici	in the past 12 months?	4□Pregnan 9□Unknow		Other (specify)	-		WORL	Day (bai
P.0	t t	Phy	9 Unknown	and a satisfication to don't	h hut ant son thin in the		on in Dant I	22a Did tal	haasa uga santributs	to the cause of death?
ŝ	S C 0	þ	Part II. Other significant conditi	ons contributing to deat	n but not resulting in the t	inderlying cause giv	ven in Parti.	239. Did (0)		Probably 4 Unknown
orc	w require been sig should b	ted						_	33 2 2 3 40 0 0	1 location 4 domination
Records,	law as b	Completed						24a. Was a autops	y prior	autopsy findings available to completion of cause of
	Th ate pag	Co						perform	med? death	
Viital	ysiclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner?			104		Death (Check only on		
o	shys this al dii	2	1 Yes 2 No	Hospital: 1 Inp.		III 3LI DOA		ng Home 5 Reside		pecify)
n (		lon	27. Manner of Death 1 ☐Natural 5 ☐ Pendin	19	njury 28b. Time o Day Year) Injury	Wo	ryat rk?  Yəs 2∐No	28d. Describe no	ow injury occurred	
Sig	Attending r death. ector: Afte	Icat	3 Suicide 6 Could		Injury - At home, farm, st		1195 2 110	28f Location (St	treet and Number or	Rural Route Number,
Division	in Sign	Certification:	4 Homicide determ		etc. (Specify)	reer, ractory, onice		City or Town		riarar riodie Namber,
	To the Hospitel or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier	na Physicien: To the be	est of my knowledge, deal	th occurred at the te	me, date and o	lace, and due to the ca	ause(s) and manner	as stated.
	24 h	edical			s of examination and/or in					
	To the To the Comple	Me	29b. Signature and title of certific	yr.		29c. Licens	se number	2	9d. Date signed (Mo	onth, Day, Year)
)			> My / x	Moure of	N	0.7	2036		4/14/90	104
	1		30. Name and address of person	who completed cause of	of death (Item 23a) (Type					
	`		Gary J S	nowse	2108 000	charte Dr	rem (	Charles N	102166	4
	Sta	ite	31. Date filed (Month, Day, Year	32. Reg	istrar's Signature					
6.	Regist	rar	APR 2 6 2004	Jan Marie	po popo	acks				

	GEORGE	BE	ECKER 1 - Stata Registrar	State of Ma Item #7,23a,	27,28a	d/Depa f per Ce	artment of b	lealth and 5/04 tas Death	Mental H	ygien	e 20	04	1290
			Decedent's Name (First, Middle, Las						2. Date of D	eath		Year	3. Time of Death
	Physici /Medio		George			Becl	ker		APRI:	L Ĭ	9, 20	04	2120 P
ì	Examir		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of De	eath		c. County		
			UNIVERSITY HOSP		/In usa la	and fainth days	BALT:	IMORE C		lieth		O. Dieth	alana (Chata as Fami
	Funeral Director		5. Social Security Number 6. Se 139-07-9829	3x 7. Age XM 2□F 8		a <i>st birthday)</i> Yrs.	Months Days		lin. 8. Date of B (Month, L Sept 2	ay, Yea	21	Coul	place (State or Foreigntry)
Č.			Usual Residence of Decedent				ì	<u> </u>	Dept 2		/21	140 •	
	rylan.		10a. State 10b. County MD. Anne Aru	ndo1		Town or Lo erna ]						1	10d. Inside City Limit
	the Marylan 28a-f show notified at	Director		ildei	Sevi	erna i							1 ☐ Yes 2 ☐XN
	vith th	Dire	10e. Street and Number				10f. Zip Code	16		10g. C	Citizen of W		ntry?
	death with the Maryland ma 23a or 28a-f show fraust be notified at	erai	715 Benfield RD	12. Was Decedent E	ver in U.S	13	211		(Specify Yes or N	ln-	,	SA - Americ	can Indian,
36	or its	by Funeral	1 □ Never Married 2 □ Married 3 🎇 Widowed 4 □ Divorced	Armed Forces? 1 X Yes 2 □ N II Xes, Give Year or Dates:		I	Was Decedent of H II Yes, specify Cuba 1 ☐ Yes 2 🂢 No		ierto Rican, etc.)	.0		k, White,	
21215-0036	72 hours "neturel",	ted	15. Decedent's Ed (Specify only highest gra	lucation		16a. Dece	dent's Usual Occup	nation	working	16b.	Kind of Bu	siness/In	dustry
218	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NDT use retired	d)	HOIKING	Δ	Automo	ntive	۵
21	e filed within al Hygiene. I other then "	Con	12	04		Mecha	anical En		1 (Fina Adida)				
and	tal H	Be	17. Father's Name (First, Middle, Last) Charles		B	ecker		Clar	Name (First, Middi	е, маюе	Breen		
Maryland	2 should be and Mental Is marked raumatic ev	유	19a. Informant's Name/Relationship (7	Type Print)			ng Address (Street			ber City			Code)
	s 1 end 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, ILAM		Kimberly B. Gomo1	** *	20h. Pla	P.O.	BOX 253	Edgewa		1037			
Baltimore,	Page: nent o ant: If ary or		1 ☐ Burial 2 🛣 Cremation 3 ☐  • 4 ☐ Donation 5 ☐ Other (Specify	')	Met	ro Cre	matory or other place ematory		24-04	Ba1	timor	e,MI	O
Ball	permit. Departr Importe any inju		21. Signature of Fune/al Service Licen	"The Mill	1	Hã	2. Name and Addre ardesty F	ss of Facility uneral An	Home P.A napolis,	MD <sup>12</sup>	Ride	gely	Ave.
8760,	Physician /Medical Examiner but and physician end physician end sthe pnial-transit	dicai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.	a conseque	ence of):							
Box 6	death certifie attending	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. Il yes, outcome de la Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3[	Ectopic pregnancy Other (specify)	/			23d. Date Mon		ery Day Year
ds, P.O.	requires that the deen signed by the	by	Part II. Other significant conditions co	ontributing to death bu	ıt not resul	lting in the u	nderlying cause giv	en in Part I.		tobacco		bute to th	he cause of death?
Ö	> 0 to	Completed							24a. Wa	c an	24h W	lere auto	psy findings available
Re	has has	m d							- auto	opsy formed?	PI	nor to con	mpletion of cause of
ā		CO	25. Was case referred to medical					26 Place of C	12 Xes Death (Check only	2 N	0 11	Yes	2 No
>	Physician: this certific at director,	0 B	examiner? 1 ∑Yes 2 ☐ No	Hospital: XXInpatie	nt 2 E	R/Outpatier	nt 3 DOA Oth	er	Home 5□Res		6 □Othe	r (Specifi	(y)
0	ding Physician: n. Alter this certific funeral director,	n: T	27. Manner of Death	28a. Date of Injur	v .	28b. Time o	28c. Injur	y at k?	28d. Describe	how inj	ury occurre	d	
Division of Vital Records,	tend leath tor: the	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  5 Pending investigation 6 Could not be determined	4-9-04	iry - At hon	Inknown	M 1 🗆	Yes 2 No	Subject S  28f. Location City or To Severna	(Street a	ind/15 <sup>b</sup> E		e Han Road Tal Road
	To the Hospital or At within 24 hours after or To the Funaral Diract completely tilled in by	edical C		ysician: To the best of niner: On the basis of and manner sta	examination				ice, and due to the	cause(	s) and man		
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1			29c. Licens				_	(Month,	Day, Year)
	X		) quest				0.C.	M.E		AI	PRIL	23	,2004
	9 Sing		30. Name and address of person who d				Print) n Street,	, Baltin	nore, Mar	ylar	nd 21	201	
	Sta	- 9	31. Date liled (Month, Day, Year)	32. Registra			_						
DH	Registi		APR 2 6 2004	Rome	H. A	Good	,	-					

			For State Registrar	State	of Mar	yland / Do	epartmer Certificat					giene , Reg. No. 2	2004	12902
			Decedent's Name (First, Middle, L.	ast)							2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medio		Laura	Μ	Be	ergmann					April	21, 2	2004	10:50 A <sup>M</sup>
No.	Examin		4a. Facility Name (If not institution, gi		umber)				Location of	of Death				
			2724 Cedar Driv		T 4 /	la last blat		Riva	If Under	24 Hrs	0 Date of Rist	Anne Arundel		
r	Funeral Director			Sex 1 □ M 2 <b>XX</b> F	57	In yrs. last birth Yr	Months	Days	Hours	Min.	8. Date of Birt (Month, Da) 1-29-1	th, Day, Year) Country)		
			Usuat Residence of Decedent		57						1-23-1	711	riai	yıana
	how		10a. State 10b. County		1	0c. City, Town	or Location							10d. tnside City Limits
	Ba-f	cto	Maryland   Anne Ar	undel		F	Riva							1 ☐ Yes 2 XNo
	with th	D I	10e. Street and Number 2724 Cedar Dri					21140	`				on of What Co USA	ountry?
	eath v	eral	11. Maritat Status	12. Was De	cedent Ev	er in U.S.				gin? (Spe	cify Yes or No		I. Race - Ame	erican Indian,
9	within 72 hours after death with the Maryland ane. then "natural", or litems 23a or 28a-f ehow the Medical Erandi at must be notified at	Funeral Director	1 ☐ Never Married 2 ☒ Married	Armed F	orces? 2 🛣 No		If Yes, spe 1 ☐ Yes		Specify:		ecify Yes or No- Rican, etc.)		Btack, Whit	
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or	Dates:								· · · · · · · · · · · · · · · · · · ·	<i>h</i> ite
15-	"nati	Completed	15. Decedent's E (Specify only highest g	rade completed		(0	ecedent's Usu Give kind of wo ife. DO NOT u	rk done d	uring mos	t of worki	ng	16b. Kind	d of Business	Industry
12	filed within Hygiene. other then "	ωo	Elementary/Secondary (0-12)	Cotlege	(1-4or 5+)		Legal			17		L	aw	
	be filed v tal Hygie d other i	Bec	17. Father's Name (First, Middle, Las	t)	-						(First, Middle,	Maiden St	umame)	
Maryland		10	Robert	S. Che	nowit						rley Kr			
Jar	C1 00 == E	1	19a. Informant's Name/Relationship		_1						Route Numbe		Town, State, 2	Zip Code)
	s 1 and if Health item 27 other tr		George E. Bergm  20a. Method of Disposition	ann/ Hu	spanc	20b. Place of D	Disposition (Nat	me of			a, MD 2		ation - City or	Town, State
nor	0 0		1 ☐ Burial 2 🎇 Cremation 3 I  4 ☐ Donation 5 ☐ Other (Spec		State	cemetery,	crematory or o	other place		4–25-	04			
Baltimore,	- 투분증		21. Signature of Funeral Service Mos			Natas							ewater	ral Home
ä	Depar Impo		What ! all	un							_			MD 21037
	\$		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that y one cause on	caused the	e death. Do no	t enter the mod	de of dying	rest,		Approximate Intervat Between			
	Pnysician	7.7	tmmediate Cause (Final disease or condition	_ a. (	-11	rrho	Sis							Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a	onsequence of	):							1940005
	**	ē	Sequentially list conditions,	b. Due to	orasa	onsequence of	):							17 year)
	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									1	
0,		Ex	resulting in death) Last	Due to	o (or as a	onsequence of	):							
928	icate be on physician s the buria	dica		d									- 1	
9 x	death certifica attending ph d for use as th	/Me	tF FEMALE:	23c. If yes, or	utcome of	pregnancy						230	d. Date of del	ivery
Вох	The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 \( \text{Yes} \) Yes	4☐Preg	nant at tin	Fetal death	3 ☐ Ectopic p 5 ☐ Other (st						Month	Day Year
P.O.	t the de by the tached	hys	9 Unknown	9□ Unk	nown									
	res tha	by F	Part II. Other significant conditions		death but	-	he underlying o	ause give	n in Part I.		1	1	_	the cause of death?
ord	v requir been si should	ted	Diabete	) (n)	clui		JFC				1 🗆 Y			obably 4 Unknown
Records,	e law has b	Completed									24a. Was autop		24b. Were au prior to death?	itopsy findings available completion of cause of
alF	ilcian: The l certificate ha rector, page		OF Management to modical	T							1 ☐ Yes	2 No	1 🗆 Yes	20 No
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	] Inpatient	2 ER/Outp	atient 3 Do	Othe			ne 5 Resid		Other (Soe	cifu)
101	g Physer this seral di		27. Manner of Death	28a. Date (Mo				28c. tnjury Work			28d. Describe h			
ion	anding F lath. or: After he funer.	atio	1 Natural 5 Pending investigate	on	,,, Duy 1	oar) trip	M		es 2 🗆	No				
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 286 Plac	e of Injury ding, etc.	- At home, farn 'Specify)	n, street, factor	y, office			28f. Location (S City or Tox		Number or Ru	iral Route Number,
	pital ours a eral C		29a. Certifier 1 Certifying P	hvsician: To th	e hest of	ny knowledge	death occurred	at the time	e date an	d place :	and due to the	rause(s) ar	nd manner as	stated
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Exa one)	miner: On the	basis of e nner state	camination and/	or investigation	i, in my op	inion, dea	th occurr	ed at the time, o	date and pl	lace, and due	to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	*	0		29	c. License	number	1			signed (Monti	
			1) (augo	COVE	he	Laurin	mp (	38	85	8		04	. 21.	2004
	10		30. Name and address of person who	completed cau	se of dea	th (Item 23a) (T		3-1-	Him	ore.	MO	212	<b>0</b> {	•
	Sta	ate	31. Date filed (Month, Day, Year)		-	Signature	- / 1	Jack				- 1,444	•	
	Regist		APR	2 6 200	× /	ichur-	15 A	se et	9					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 ls Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month Dev Year **Physician** 3:45Pr ARAH BROWN April 20 2004 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner **FUTURE CARE/CHESAPEAKE** ARNOLD 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1□ M 2XF Yrs. 213-24-4568 80 MAY 29, 1923 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director QUEEN ANNES CHESTER 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 1401 LITTLE CREEK ROAD 21619 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify δ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 CRAB PICKER SEAFOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNK 2 NETTIE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH DEMBY/GRANDDAUGHTER 195 RYAN ROAD PASADENA , MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 urial 2 □ Cremation 3 □ Removal from State KING MEMORIAL PARK 4-28-04 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A, MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 bolon 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a CEREBROVASCULAR Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 Ho 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

**Physician** /Medical Examiner

**Funeral** 

Director

rai', or items 23a or 28a-f shov Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and to Heatth and Mental Hygiene. ant: If Item 27 is marked other then "natural", or Items 23a or 28a-f show

3altimore, Marvland 21215-0020

Physician/Medical Examiner þ Completed å ۵ Certification:

The law requires that the death certificate be executed attending physician and I for use as the buriat-transit certificate has been si irector, page 2 should I or Attending Physician:

State

Registrar

Medical

28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) APR 2 6 2004

29b. Signature and title of certifier

601 Veter 32. Registrar's Signature

and manner stated.

DHMH 16 Rev 6/95

		-	State of Marylar  State of Marylar  Registrar	nd / Depa		lealth and M	lental Hygi	_	12904
roj.		jer.	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yeer	3. Time of Death
*	Physicia /Medic	al	NORAH W. BENNER				APRIL 23	2004	12:50 P M
	Examin	1	4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Deal	
€ .	Treps (F)	19	GENESIS HAMMONDS LANE  5. Social Security Number 6. Sex 7. Age (In yrs	last birthday)	BROOKLY If Under 1 Year	N PARK If Under 24 Hrs.	8. Date of Birth	ANNE ARU	
6.	Funeral Director		226-10-1286	Yrs.	Months Days	Hours Min.	(Month, Day, 1) Feb. 04		thplaca (State or Foreign buntry) Virg.
	4		Usual Residence of Decedent	. T.			100.04		
	show	_		ity. Town or Lo Baltimo					10d. Inside City Limits  TX□ Yes 2□ No
	28a-f	ecto	Md. n/a	Jaitino	10f. Zip Code		10	g. Citizen of What Co	
	with la or	급	415 Cambria Street			225	, ,	U.S.A.	,,
	ours after death with the Maryla ral', or Items 23a or 28a-f shov Exartifier from the rectified at	Funeral Director	11 Marital Status 12. Was Decedent Ever in U	J.S. 13.1		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
9	or Item	Fur	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give A		1 Tes, specify Cub. 1 □ Yes 2 🏋 No	an, mexican, Puerto  Specify:	Hican, etc.)	Black, Whit	
21215-0036		d by	3X Widowed 4 □ Divorced Year or Dates:						white
15	d within 72 ho giene. ir than "natui ine Modical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	ation during most of work d)	ing	6b. Kind of Business	Industry
12	withir ene. then	duc	Elementary/Secondary (0-12) College (1-4or 5+)	Sal		/	1	ontgomery	Ward
d	itled Hygir other	BeC	17. Father's Name (First, Middle, Last)				e (First, Middle, M	aiden Sumame)	
ılan	Aental Aental rked c	To B	Joseph W. Rorrer			E11a	I.	Maddox	
Maryland	s 1 and 2 should be filed v f Health and Mental Hygie Item 27 is marked other to other traumatic event, II		19a. Informant's Name/Relationship (Type, Print) Betty Besold (Daughter)			and Number or Rur rail, Aus		City or Town, State, 2 s 78724	Zip Code)
re,	es 1 and of Health f Item 27 r other tr		20a. Method of Disposition 20b.	Place of Dispo	osition (Name of matory or other pla	ce)		0c. Location - City or	Town, State
E	Pages nent of int: If h		1 Li Buriai 2   Cremation 3   Removal from State		Mem. Par	1. /29	3/04	Baltimo	re. Md.
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item any injury or otha		21. Signature of Furral Service Licensee Kevin E I	Ecker 22	2. Name and Addre	ss of Facility	ak Funera	1 Home P.	
8	80 5 5 9	1	23a. Part1. Enter the disease, or complications that caused the dec		237 E.	. Patapse	Ave. Ba	1timore.	Md. 21225
760,	Physician /Medical Examiner e parial-transit	cal Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  Due to (or as a consection of the condition of the cause).  Due to (or as a consection of the cause).  Due to (or as a consection of the cause).	equence of):				U LAR ISÉASE	Onset and Death
P.O. Box 68	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ ₩6  9 ☐ Unknown  23c. If yes, outcome of pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnanc	у		23d. Date of del Month	livery Day Year
	uires that n signed b ild be deta	b	Part II. Dther significant conditions contributing to death but not re	sulting in the u	inderlying cause gr	ven in Part I.			o the cause of death?
of Vital Records,	The law requir te has been si age 2 should l	Completed					24a. Was an autopsy perform	ed? death?	utopsy findings available completion of cause of
ita	ian: 'rtifica	a	25. Was case referred to medical			26. Place of Deat	h (Check only one		
> \	hysic his ce I direc	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA			nce 6 □Other (Spe	city)
ū	ing P		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Describe how	v injury occurred	
sio	tandi leath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be 289 Place of Injury At	hama form at		Yes 2□No	29f Location (Str	et and Number or R	usal Pauta Number
Division	l or At after d Direct I in by	ertifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spec	nome, rarm, sti	геет, гастогу, опісе		City or Town,	State)	urar noute ivumber,
/	To the Hospital or Attanding Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Certification;	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my king the control of the basis of examination and manner stated.						
	Fo the	Me	29h Signature and title of certifier		29c. Licens		29	d. Date signed (Mont	th, Day, Year)
	- > - 0		AMHLAN- MI	7	D	21776	A	PRIL 20	3 2004
	2		30. Name and address of person who completed cause of death (Its	m 23a) (Type,	Print)	31.57	BACRI	more r	3, 2004 NO 21225
	Sta Regist		31. Date filed (Month, Day, Year)  APR 2 6 2004	nature	v				

DHMH 17 Rev 1/2001

ORIGINAL

Please Ty	pe or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
8	State of Maryland / Department of Ho	ealth and Mental Hygiene 2001

			Please	State of Ma		partment of			_	
		•	1 - For State Registrar	State of the	_	ertificate of			g. No. 2001	+ 12905
	Physici /Medio		1. Decedent's Name (First, Middle, La Lauretta	st)	Cauthor	ne		2. Date of Death Month APRIL	Day Year	3. Time of Death 5:05 AM
	Examir		4a. Facility Name (If not institution, giv	e street and number) TAN has p		4b. City, Town,	or Location of Death		4c. County of Dea	MORE OITY
	Funeral Director		5. Social Security Number 6. S		e (In yrs. last birthd 72 Yrs	Months Days		8. Date of Birth (Month, Day, 4–14–32		rthplace (State or Foreign ountry)
	yland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	the Marylar 28a-f show	Director	Md. NA		Baltimo	re		10	g. Citizen of What C	y Yes 2 No ountry?
	ath with		1357 Kitmore Roa				.239		USA	
920	72 hours after death with the Maryland Instural', or Itams 23a or 28a-f show dical Examinating Colling at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S.	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No		pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
15-0	- 28	leted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(G	cedent's Usual Occu	during most of work	king	6b. Kind of Business	/Industry
d 21215-0036	2 should be filed within 72 hours and Mental Hyglein "e. attettel", is marked other than "eattrel", aumatic event, It a Modical Exa	e Completed by	Elementary/Secondary (0-12)  12th grade  17. Father's Name (First, Middle, Last,	College (1-4or 5	i+)	e. DO NOT use retire Nurse's As	st.	e (First, Middle, N	Church Hon	ne Hosp.
ylan	should be nd Mental marked c	To Be	Frank	Car	croll		Hattie		Curtis	
Maryland	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship ( Kevin Cauthorne						City or Town, State,	Zip Code)
ď			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif	Son Removal from State	20b. Place of Di cemetery, o	7 Kitmore sposition (Name of crematory or other pla	ace)	Date 2	Oc. Location - City or	
Balti	permit. Page Department of Important: if eny injury or once.		21. Signature of Funeral Service Licer		Garris	on Forest 22. Name and Addr March F.H	ess of Facility	Balti	Owings Mil More, Md. North Ave	21202
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Due to (or as	the death. Do not the.  PS   S a consequence of):		ng, such as cardiac			Approximate Interval Between Onset and Death
68769	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, baoing to in a clast cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or se	a consequence of):					
.O. Box 6	The law requires that the death certificate be exedited to the specific to the specific and the specific and the specific and specific	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 moriths? 1 □ Yes 2 □ No 9' Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	livery Day Year
rds, P	quires that in signed b uld be deta	by	Part II. Other significant conditions of	-	ut not resulting in the	a underlying cause gi	ven in Part I.		acco use contribute to	
		Completed	SEIZURE	DUCRD	ER			24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
Vita	Physicien:   rthis certifical ral director, p	o Be	25. Was case referred to medical examiner?	Hospital:		Ott	The second second	h Check on one		
o	After une	H .	1  Yes 2 No  27. Manner of Death  1  No Pending 2  Accident investigation	28a. Date of Injur (Month, Day	nt 2 ☐ ER/Outpa y Year) 28b. Time Injur	of 28c. Inju	4 Li Nursing Ho	me 5 ☐ Resider 28d. Describe how	ice 6 □Other (Spe v injury occurred	cify)
<u></u>	el or Attend s after death al Director: ,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospitel or Atterwithin 24 hours after de To the Funarel Directo completely filled in by the	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination and/or	eath occurred at the ti	me, date and place, opinion, death occuri	and due to the car red at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
	To the To the Complet	Me	29b. Signature and title of certifier  NTI COM NO.	tel MI	)	RES			Date signed (Month	
	3		30. Name and address of person who NILESH PATEL	completed cause of d	eath (Item 23a) (Typ	RAVEN BO	ULEUARP	, BALTIN	nore, MD	21239
	Sta	te-	31. Date filed (Month, Day, Year)	32. Registra	r's Signature		S.			



			1 - For State Registrar	State of Maryla		artment of F			giene Reg. No. 2004	12906
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Joseph T. D'Al	esandro S	r.		•	2. Date of De Month April		3. Time of Death 9:35a M
	Examir		4a. Facility Name (If not institution, give s		_	-	r Location of Death	1	4c. County of Dea	
			Manor Care 509 5. Social Security Number 6. Sex		Rd. s. last birthday)	Towsor	If Under 24 Hrs.	8. Date of Bird	Baltimo	
	Funeral Director			_	6 Yrs.	Months Days	Hours Min.	7-8-19	y, Year) Co	thplace (State or Foreign buntry) Limore, MD
	a-f show	ctor	10a. State 10b. County n/a		city, Town or Lo	cation Italy ,	Baltimo	re		10d. Inside City Limits 1X Yes 2 ☐ No
	th with the 23s or 28 ust be no	rai Director	10e. Street and Number 245 Albemarle S	treet		10f. Zip Code	21201		10g. Citizen of What Co	puntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show apply injury or other traumatic event. Ite Marice Exercite to the first and Dece.	by Funeral	11. Marital Status  1. Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces?  1 X Yes 2 \sum No A: If Yes, Give Year or Dates: 196	rmy	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
1215-0	within 72 h ane. than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done DO NOT use retired Aministi	during most of won d)	king	16b. Kind of Business, City of E	,
Maryland 21215-0036	uld be filed fental Hygid rked other tic event.	To Be Co	17. Father's Name (First, Middle, Last) Thomas J. D'Ale				18. Mother's Nam	ne (First, Middle, nciata	Maiden Sumame) Lombardi	
	and 2 shousaith and Mastrand Mastrand Mastrand		19a. Informant's Name/Relationship (Type Thomas J. D'Ale	<sup>g, Print)</sup> brothe sandro III	19b. Mailin	g Address (Street Walnut	and Number or Ru Wood (	ral Route Numbe Circle	er, City or Town, State, 2 Baltimore	Zip Code) 2 , MD 21212
Baltimore,	Pages 1		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐ Re  1 ☐ Donation 5 ☐ Other (Specify)	moval from State	ew Cat	hedral	4/26		20c. Location - City or Baltimore	, MD
Ball	permit Depart Import any inj		21. Signature of Funeral Service License	more	26	53 S. Co	nkling	St. Ba	Zannino ltimore,M	Jr. FH ID 21224
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only, one Immediate Cause (Final disease or condition resulting in death)	ESOPHAGE	AL (	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a conse	equence of):					
8760,	rate be executed shysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	c. If yes, outcome of pregr 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal déath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	w requires that been signed by should be deta	by	Part II. Other significant conditions cont	ibuting to death but not re	sulting in the un	derlying cause give	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Vital Records,	Physicien: The law requ this certificate has been ral director, page 2 should	Completed						24a. Was a autop perfor	sy prior to c	topsy findings available ompletion of cause of
	Attending Physicien: The death. ector: After this certificate by the funeral director, pag	Be c	25. Was case referred to medical examiner?  1  Yes 2 No	spital:	Jeno	Othe	26. Place of Deat	4 703.6		
ō	g Phys er this ieral di	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work	4 Nursing Ho		ence 6  Other (Specow injury occurred	ify)
Sion	death. ctor: Aft the fun	atio	1 Matural 5 Pending 2 Accident investigation	(MON(II, Day 19al)	Injury		res 2 □ No			
Division of	tal or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre ify)	eet, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	one)	cian: To the best of my kr ir: On the basis of examinand manner stated.	lowledge, death ation and/or inv	estigation, in my op	pinion, death occur	red at the time, o	late and place, and due	to the cause(s)
)	5 m C 0	~	29b. Signature and title of certifier  Multiple 1	elymo			0433	2	PPRIL 23	2004 MD 21204
	611		30. Name and address of person who con	BMC 6	101 N		25 51	BA	TIMORE	mo 21204
	Sta Registr		31. DAPR (2004 Day Year)	32. Registrar's Sign	Seek!					

			For State Registrar	State of M	laryland .				ealth a		lental Hy	ygien Reg. N	2001	12907
	Physici		Decedent's Name (First, Middle, Last		es Earl	l Dat	ic				2. Date of D Month April	D	ay Yeer	3. Time of Death 9:36 p M
	/Medic Examin		4a. Fecility Name (If not institution, give			Dav		Town, or	Location of	of Death	APLII		c. County of Dea	
	Exami		Laurel Regional I	Hospital			Lauı	rel					Prince 0	George
	Funeral		Social Security Number     6. Se	x 7. A	ge (In yrs. last		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	ay, Yee	r)   Co	thplace (State or Foreign
	Director		577-60-8460	Ala SOL	56	Yrs.					May 2	6, 1	947   Was	shington, DC
	ow in		10a. State 10b. County	-	10c. City, T	own or Lo	cation							10d. Inside City Limits
	Mary a-f sh	tor	MD Prince (	George	Laure	e1								1 ☐ Yes 2 💆 No
	or 28.	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What Co	ountry?
	ath w	ral	14702 Shiloh Cou				207						S.A.	
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or liems 23s or 28s-f show that the Medical Examiner must be notilised at	Funeral	11. Marital Status	Armed Forces	?	13.	Was Dece I Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit	
38	II', or	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	140		1 🗆 Yes	2 <b>X</b> ) No	Specify:				Specify: Wh	ite
Maryland 21215-0036	2 hou	ted	15. Decedent's Ed		1	6a. Dece	dent's Usua	al Occupa	ation during mos	t of works		16b. l	Kind of Business	
21	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	se retired,	)	I OI WOIKI	ng			
7	led w lygien her th		7		1	Manag	er		40 14-45		15: A6: 4.4		staurant	
and	ould be fi Mental H arked otl atic ever	Be	17. Father's Name (First, Middle, Last)  James Edwin Davis							y Hei	(First, Middle	e, Maide	n Sumame)	
<u> </u>	should ind Men ind Men in marke	L <sub>O</sub>	19a. Informant's Name/Relationship (T)		1	19b. Mailir	a Address	(Street a				ber City	or Town, State, 2	Zin Code)
	and 2 sealth ar n 27 is ner trau			ouse			-						Marylan	
altimore,	of Her item item		20a. Method of Disposition		20b. Place	e of Dispo		ne of		_	ate	,	ocation - City or	
Ē	Pages nent of f ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 8  '4 ☐ Donation 5 ☐ Other (Specify,		) ]	-	•		. )	pr 2	7,2004	Dor	sey, Ma	ryland
alt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at Once.		21. Signature of Funeral Service Livens	00		22 D	. Name an	d Addres	s of Facilit	y cal H	Home, I	P.A.		
_	80539		Web itt yas	lly	M00773	3 3	13 Ta	1bot	t Ave	e. La	urel,	Mary	yland 20	707-4389
	Physician		23a. Part1. Enter the isease, or composhock, or he in allure. List only of limmediate Caus. Fin disease or condition	ne cause on each I	ine.					cardiac c	r respiratory a	arrest,		Approximate Interval Between Onset and Death I hour
-	/Medical		resulting in death)	u	s a consequen		III. aı	. С . 1 С	/11					1 Hour
	Examiner	_	Sequentially list conditions, if any, leading to immediate	b	ry arte		iseas	se						sev. yrs.
	led Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ce or):								
	icate be executed physician and s the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as	a consequen	ce of):								- <del></del>
8760,	s be	dlcal		d										
68	tificat ng phy as th	Medi												
Вох	The law requires that the death centificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth			Ectopic pr	egnancy					23d. Date of del Month	ivery Day Year
o.	the all	ysic	1 Tes 2 No	4□Pregnant a 9□Unknown	it time of death	5 □	Other (sp	ecity)					WOTE	Day Toal
P. 0.	that the ed by detac	Ph	Part II. Other significant conditions co	ntributing to death t	but not resultin	g in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco	use contribute to	the cause of death?
ds,	w requires that been signed to should be det	d by	Diabetes mellitis				, -				1 🗆	Yes 2	No 3⊠Pr	obably 4 Unknown
00	w req	lete									24a. Was	s an	24b. Were au	itopsy findings available
Re	The fav te has age 2	Completed									auto	psy ormed?	prior to death?	completion of cause of
a	ian: rtifica	BeC	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes		0 1 ☐ Yes	2 140
<u>_</u>	hysic his ce I direc	ToE	examiner? 1 □ Yes 2 🔀 No	Hospital: 1 ☐ Inpati		Outpatien		Othe	r: 4 □ Nu	rsing Hor	ne 5□Res	idence	6 □Other (Spec	cify)
Division of Vital Records,	Attending Physician: r death. ector: After this certifics by the funeral director. I		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28l	b. Time of Injury		8c. Injury Work	at ?	2	28d. Describe			
<u>sio</u>	death death tor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Disea of le	ium. At home	form at-	M	1	/es 2 □ f	-	Of Logation	/Ctract a	and Alumbar as O	ıral Route Number,
<u>&gt;</u>	after after Direct Jin by	Certification:	4 Homicide determined	28e. Place of In building, e	tc. (Specify)	, raim, su	et, ractory	, office			City or To			irai rioute Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 ☐ Certifying Phy 2 ☐ Medical Exami	sician: To the best ner: On the basis of and manner st	of examination	dge, death and/or inv	occurred restigation,	at the tim	e, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s	s) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	A			290	. License	number			29d. Da	ate signed (Mont/	h, Dey, Year)
)	r s r ō			E ZI	- N	1. 1	, Г	2472	1			Anr	il 26,	2004
	10		30. Name and address of person who co	ompleted cause of	death (Item 23	a) (Type,						2301		2003
	,		Syed Sadiq, M.D.	14333	Laurel-	Bowi	e Roa	d	Laure	1, M	Marylan	d 20	708	
	Sta Registr		31. Date liled (Month, Day, Year)  APR 2. 6. 2004	32. Regist	rar's Signature	10	als	/						<del></del>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Audrey R. Dugent 0840AM April 21 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Cheaspeak Hospital Bel Air Harford 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State Country)
Dec. 31, 1920 Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Months Days Min. Hours 83 Yrs. 214-18-2810 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits item 27 is marked other than "natural", or frams 23a or 28e-1 show other traumatic avent, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Director MD Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 744 Shore Drive 21085 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐ Yes 2**X** No Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Glen L. Martin Co. Data Processor 11th Pagas 1 and 2 should ba filed a nent of Health and Mental Hygic int: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Gordon Geneva Lathe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 Joppa Farm Road Joppa MD 21085 Sharon Youmans/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State HollyHillCemetery 4/24/04 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ConnellyFuneralHomeofEssex onne 300 MAce Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death. Go not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List party pne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 who /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetat death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Cher (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 Tes 2 ER/Outpatient 3□ DOA

Dugent, Audrey within 24 hours after death To the Funerel Director: , completely filled in by the f

27. Manner of Death

Natural 5 Pending 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

investigation

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year) 04-22-2004

State Registrar

Certification:

Medical

29a. Certifier

(Check only one) 29b. Signature and title of

31. Date filed (Month, Day, Year)

1308 Bu

APR 2 6 2004

32. Registrar's Signature

Way

			1 - For State Registrar		State of M	larylan	d / Depa		t of H	ealth a	and N	fental Hyg	iene .		12	909
ı	Physici	an	Decedent's Name (First, I     T. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				_					2. Date of Dea Month		Year	3. Time of	
	/Media	cal	Hilda		rraine			Dove				April April	Day 22	2004	1:10	р м
	Examir	ier	4a. Facility Name (If not inst 3658 Solomo			•			Town, or Harw	Location o	of Death			ounty of Death	. 1 1	
	Euparal		5. Social Security Number	6. Sex			last birthday)	If Under		If Under	24 Hrs.	8. Date of Birth		nne Ar		r Foreign
	Funeral Director		216-28-5780 Usual Residence of Decede	1 □ M	2 <b>∑</b> F	73		Months	Days	Hours	Min.	Sept.	, Year)		olace (State ontry)  yland	r r oreign
	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Medical Erar in et r. ust be ricitified at		10a. State 10b. Co	ounty		10c. City	y, Town or Lo	cation							10d. Inside Ci	
	er death with the Marylar tams 23a or 28a-f show et instite the collised at	Director	MD Ann	e Arund	el	I	Harwood	1.							1 ☐ Yes	2X No
	or 24	듬	10e. Street and Number					10f. Zip	Code			1	0g. Citizer	of What Cou	ntry?	
	s 23s		3658 Solomo							776				USA		
	itams	Funeral	11. Marital Status 1 ☐ Never Married 2		Was Decedent	?	.S. 13. \	Was Decedo f Yes, spec	ent of Hi ify Cubai	spanic Ori n, Mexicar	gin? (Sp. 1, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
36	irs aft	by F	3 ☐ Widowed 4 ☐ Dive		1 ☐ Yes 2X If Yes, Give Year or Dates:	NO		I□Yes 2	X No	Specify:			Sp	ecity: Wh	ite	
Ö	2 hou	ted	15. Dec	edent's Educati	on		16a. Deced	lent's Usua	I Occupa	ition			16b. Kind	of Business/In	dustry	
21215-0036	hin 7. 9. Medi	ple	(Specify only I Elementary/Secondary (0	nighest grade co	College (1-4or	5+)	(Give life. l	kind of wor DO NOT us	k done d e retired)	uring mos	t of work	ing			,	
7	be tiled within 72 hours afte ital Hygiene. Ind other then "natural", or I evant, the Medical Exami	Completed	10				Home	maker					Own	Home		
nd	be file tal Hy d oth	Be	17. Father's Name (First, Mi	-						18. Mothe	er's Name	e (First, Middle,	Maiden Su	mame)		
yla	should be and Mental marked o umatic eve	은	James P. Ire									oeth Rod				
Maryland	S a a a		19a. Informant's Name/Reia Wilson H. Do		•	and)						al Route Number				
	1 an Heal		20a. Method of Disposition	, , , , , ,	(IIdaba	20b. P	lace of Dispo	sition (Nam	e of			Rd., Har		ion - City or To		
Baltimore,	permit. Pages Department of I Important: If its any injury or of		XXBurial 2 Crema	tion 3 Rem	oval from State	, a	emetery, cren	natory or oti	her place	- 1						
ij	artme ortan injury		*4 □ Donation 5 □ Oth  21. Signature → Fone al Se		1.1	Lake	emont 1							lsonvi1	le, MD	
Ba	Dermi Depa Impo any i		21. Signature of Fone all Service Licensee  22. Name and Address of Facility Hardesty Funeral Home, P.A.  12 Ridgely Avenue, Annapolis, M										MD 21/	.01		
			23a. Part1. Enter the disease shock, or heart failure.	se, or complicati	ions that cause	d the death	n. Do not ente							<u> FID 212</u>	Approximate Interval Bety	)
ı	Physician		Immediate Cause (Final disease or condition	List offiny offie C	AI	7	imer		10	0-4	'a			-	Onset and E	veen eath
ı	/Medical		resulting in death)	a	Due to (or as				le m	010				1		
п	Examiner	L	Sequentially list conditions,	b												
	ed isit	lne	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	~	Due to (or as	a consequ	uence of):							h		
	xecut and al-tran	Examln	that initiated events resulting in death) Last	c	Due to (or as	a consequ	uence of):									
8760,	ate be executed hysician and the burial-transit	calE				•										
9	death certificate be executed e attending physician and id for use as the burial-transit			0			0.001									
Box	leath certifical attending phy d for use as th	N/U	IF FEMALE: 23b. Was decedent pregnar	IL I	If yes, outcome 1□Live birth			Ectopic pre					23d.	. Date of delive	ту	
	ne deat the att hed for	Physician/Med	in the past 12 months?		4☐Pregnant a			Other (spe						Month	Day Y	ear
P.0.	that the de ed by the detached	Phy	9 Unknown	1												
	se ugu	by	Part II. Other significant co				_	derlying ca	use give	n in Part I.			_	contribute to th	_	
ecords,	w requir been s should	eted	cerebi			an sea	26		-			1  Ye	s 2 N	o 3 🗆 Prob	abiy 4 □U	nknown
3ec	e faw has b	Completed	diabet									24a. Was a autops	y   -		osy findings a npletion of ca	vailable use of
al B	Th ate		hyper		n							perform	No No	death?	2 No	
Vital		o Be	25. Was case referred to me examiner? 1 ☐ Yes 2 2 No	Hosp	oital:							(Check only on				
of	Phys	$\vdash$	27. Manner of Death		8a. Date of Inju	IIV	ER/Outpatient 28b. Time of		c. Injury	4 ∐ Nui at		ne 5. Reside			")	_
ion	Attanding It death. actor: After by the fune	atlor		ending vestigation	(Month, Da	ıy Year)	Injury	М	Work'	? es 2 □ N			,,			
Division	Attandiar death.	ifica		ould not be 2	8e. Place of In	jury - At ho	me, farm, stre	et, factory,	office		1	28f. Location (Str	eet and N	umber or Rura	Route Numb	er,
	s after or sale	Certification;	4 - Homodo		building, et	с. (эрөспу	7				1	City or Town	, State)			
	To tha Mospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical	Check only 2 Med	tifying Physicia	on: To the best	of my know	wledge, death	occurred a	t the time	a, date and	d place, a	and due to the ca	use(s) and	manner as st	ated.	
	To tha h within 24 To tha F	Medi	0110)		and manner st	ated.										
	To To	-	29b. Signature and title of co		R	mas			License		7			gned (Month, I		
,	13			no	2	717		1	170	101	<i>O</i>		7-2	3-0<	1	
	1		30. Name and address of pe	rson who compl	integration of cause of c	eath (Item	23a) (Type, F	rint)	Post	11	bet	-River	m	D 2n	720	
	· Sta	te	31. Date filed (Manin Payer	(00) man	32. Registr	ar's Signat	ure	110		,00	7)	0-00	/	000	178	
	Registr		APK &	U ZUK	Blings	CAPOLI	10	Low	and in	/		-River				

			1 - For State Registrar	State of Mary			nt of Hea te of De		-	giene Reg. No. 20 (	)4 12911
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give s  University Special		ee Dan	aiels 4b. City Bal	, Town, or Loca	ation of Death	2. Date of Dea	Day Yea 21 2004 4c. County of De	13.20 M
	Funeral Director		5. Social Security Number 6. Sex 227=52-4041	M 2□F	yrs. last birthda 68 Yrs.	Months		Inder 24 Hrs. ours Min.	8. Date of Birt (Month, Da 4 1	9. B 8 1936	irthplace (State or Foreign Country) N . C .
	death with the Maryland ms 23a or 28a-f show rmst be notified at	rector	10a. State 10b. County Md N/A		c. City, Town or Balto		ip Code			10g. Citizen of What (	10d. Inside City Limits  1 Yes 2 □ No  Country?
noch	(036) ours after death with the Manylan ral', or Items 23a or 28a-f show Evaniner must be notified at	by Funeral Director	2117 N. Dukeland  11. Marital Status  12. Married 2 Married 3   Widowed 4   Divorced	Street  2. Was Decedent Ever Armed Forces? 1 Yes, Give Year, or Dates:	in U.S.	3. Was Dec If Yes, sp	edent of Hispan ecify Cuban, Me	217 ic Origin? (Speaxican, Puerto ecity:	ecify Yes or No- Rican, etc.)	USA	nerican Indian, lite, etc.
	21215-0 ad within 72 ho giene. er than "natui the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 7th grade	eation	(Gir	cedent's Us ve kind of w . DO NOT truct				16b. Kind of Busines Aberdeen	,
Qi.	laryland 212 2 should be filed with and Mental Hygiene is marked other tha aumatic event, tha	To Be	17. Father's Name (First, Middle, Last) Ollie L. Daniels  19a. Informant's Name/Relationship (Type	pe, Print)	19b. Ma	iling Addres		Beatrio	e Jol	Maiden Sumame) nnson ir, City or Town, State,	Zip Code)
Daniec	Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once.		Timecka L. White —  20a. Method of Disposition  1	emoval from State	Ob. Place of Dis cemetery, cr King Me	position (Na rematory or moria	other place)	4-27-	-2004	lto, Md 20c. Location - City of Randalls	
	Physician /Medical Examiner		23a. Part I Enter the disease, or complication of the complete cause (Final disease or condition resulting in death)	cations that ceused the e cause on each line.  Due to (or as a con	ric 1	enter the mo	4300 ide of dying, sur	Wabash	arch F/I Avenue r respiratory ar	Balto.	MA 21215 Approximate Interval Between Onset and Death
	is 760, icate be executed physician and si the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	ro va	2 Cru	las a	eerd	auf		Yrs Yrs
1	C. BOX 6: It he death certific by the attending p	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	ac. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	B⊟Ectopic ( B⊟ Other (s				23d. Date of di Month	elivery Day Year
	COLDS, P w requires that been signed t should be deta		Part II. Other significant conditions con-	tributing to death but no	ot resulting in the	underlying	cause given in	Part I.	1 🗆 Y	es 2 No 3 F	to the cause of death?  Probably 4 2 Unknown
	Vital Rec sician: The law certificate has b	e Completed	25. Was case referred to medical				26.	Place of Death	24a. Was a autop perfor 1 Yes	sy prior to med? death? 2.☑No 1 □ Ye	
	sion of anding Phys ath. r: After this ne funeral di	cation; To B	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpati 28b. Time Injury		O11	☐ Nursing Hon	ne 5 🗆 Resid	ence 6 □Other (Sp ow injury occurred	ecify)
¥;	DIVIS  To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	I Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)	pecify)				City or Tow		
4	To the Hos within 24 ho To the Fun completely it	Medicai	29a. Certifier (Check only one) 2 Medical Examin	ician: To the best of my er: On the basis of exa- and manner stated.	mination and/or	investigatio	n, in my opinion	, death occurre	ed at the time, o	late and place, and du	e to the cause(s)  ith, Day, Year)
	8		30. Name and address of person who cor	mpleted cause of death	(Item 23a) (Type	e, Print)				pril, 21	5+2004 10×2 MD21230
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 6 2004	32. Registrar's S		locat.		Cha	102 5	ot, 1xatin	1082 MD21230

			1 - For St	ate of Maryla	and / Depa	artment o				ne 2001	12911
			Decedent's Name (First, Middle, Last)			imouto	or Douir	2. Date of	f Death		3. Time of Death
	Physici /Medio		Rose I	)as.				Month	, c	Day Year	7 A.M.
1	Examir		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Tox	wn, or Location		4	c. County of Dea	ith
			4229 Sheldon Avenue				more Ci		E	Baltimore	e City
	Funeral		5. Social Security Number 6. Sex		rs. last birthday)  Yrs.	If Under 1 Y Months D	/ear If Under Days Hours	Min. 8. Date of (Month	f Birth , <i>Day</i> , Yea	9. Bir	thplace (State or Foreign ountry)
	Director		215~07~9564 Usual Residence of Decedent	/				12	25	Max Max	ryland
	yland		10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
	a-f si	ctor	Maryland Baltimore C	ity	Balti	more C	itv				1√Yes 2□No
	or 28	Dire	10e. Street and Number	•		10f. Zip Co	ode		10g. 0	Citizen of What C	ountry?
	s 23a	ral	4229 Sheldon AVenue				206			USA	
	ter de Item	Funeral Director	A	Vas Decedent Ever in Immed Forces?	1 U.S.   13. V	Nas Decedeni f Yes, specify	t of Hispanic Oi Cuban, Mexica	rigin? (Specify Yes o in, Puerto Rican, etc	r No- .)	14. Race - Ami Black, Whi	
336	urs af	þ	₩ Widowed 4 Divorced	Yes No Yes, Give Year or Dates:	1	Yes XX	No Specify	**		Specify: Whi	te
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show he Madical Everthier must be colified at	Completed	15. Decedent's Education	n n		lent's Usual O		- A - A dili	16b.	Kind of Business	
21	ithin 7	nple	(Specify only highest grade con Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use r	do <i>ne during</i> mo: reti <i>red)</i>	st or working			
	filed with Hygiene other than			/ A	Hous	ewife					ng~Own Home
anc	d be fi	Be	17. Father's Name (First, Middle, Last)  Karol Samuel Sowa					er's Name (First, Mi		· ·	
Maryland	2 should be find and Mental His marked of	卢	19a. Informant's Name/Relationship (Type, F	Print)	19b. Mailin	a Address (St		oria Kuni Per or Rural Route Ni			Zin Code)
	1 and 2 : Health ar iem 27 is		Gerard D. Das (Son)	,				Monkton,			
J.	of Head		20a. Method of Disposition		. Place of Dispos cemetery, cren	natory or other	r place)	Date	20c.	Location - City or	Town, State
<u>Ë</u>	Pages ment of I ent: If its ury or o		Marial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	State State	. Josep	h Ceme	tery	4~23~2004	Ful	lerton,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	///	22 La	Name and A	ddress of Facil	T Home			
	# # # # # #					401 Bel	lair Rd	. Baltimo	ce, Ma	aryland	21236
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one callimmediate Cause (Final)	use on each line.	eath. Do not ente	er the mode of	r dying, such as	1	- 4		Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	11/100	and	ian	. 7	Meuro	Li o	<b>^</b>	
	Examiner			Due to (ar a a cons	equence or;			V			
		ner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dualto (or as a cons	requence of):						
	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
8760,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	E	resulting in death) Last	Due to (or as a cons	equence of):						
687	physics the	edical	d.							_	
Вох	leath certific attending pi	N/W		yes, outcome of pred						23d. Date of del	livery
Ď.	death e atte	Physiclan/Med	in the past 12 months?	Live birth 2 Fe		Ectopic pregn Other (specif				Month	Day Year
P.O.	that the de ned by the a detached f	hys	9 Unknown	Unknown							
Ś	signed be det	by	Part II. Other significant conditions contribu	ting to death but not r	esulting in the un	iderlying caus	e given in Part I			× /	the cause of death?
O.C	w requir been si should	eted		J.C.	10	~~\~\	ely	1	☐ Yes 2	/	obably 4 Unknown
Records,	has b	Completed					7	a	Vas an utopsy erformed?	24b. Were au prior to death?	stopsy findings available completion of cause of
E	iclen: The l certificate harector, page	မ Co	25. Was case referred to medical					1 🗆 Ye	s 2 N		\$\times \( n_0 \)
Vital	/sicle s cert direct	To B	examiner?  1 Yes 2 Hospit	tal: 1 ☐ Inpatient 2	☐ ER/Outpatient	3 🗆 DOA	Othor	e of Death <i>(Check or</i> ursing Home		6 DOthor (Sac	-(4.)
J of	ding Phys h. After this funeral di		27. Manner of D ath 28	a. Date of Injury (Month, Day Year)	28b. Time of		Injury at Work?		-	ury occurred	cny)
Sio	endin sath. or: Af he fur	atlo	1 Accident 5 Pending investigation	(1101111) 247 7041)	Inquity	М	1 Yes 2	No			
Division	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	e. Place of Injury - At building, etc. (Spe	t home, farm, stre	et, factory, off	fice	28f. Location City or	n (Street a Town, Sta	and Number or Ru te)	ıral Route Number,
	pitel ours a erel C		29a. Certifier Cartifying Physician	to To the best of our l	roculadas daeth						
	To the Hospitel or Attending Physiclen: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Examiner: (	On the basis of examined manner stated.	ination and/or inv	estigation, in r	ne time, date an my opinion, dea	nd place, and due to ath occurred at the tir	the cause(: ne, date ar	s) and manner as nd place, and due	to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	3		29c. Lic	cense number		29d. D	ate signed (Monti	h, Day, Year)
	0	,	1 Wess	No.	an	1	346	105	(	1/20	104
	1.0		30. Name and address of person who comple	ted cause of death (It	tem 23a) (Type, F	Print)		2 2		Ann	WAD-
			31. Date filled (Month, Day, Year)	22. Registrar's Sig	inature ,	312	, (	W Orw	un	1400	21213
	Sta Registr		APR 2 6 2004	2. Hogistial's Sig	1. Ange	( )					
		2	APR & D LUU4	I down the stand I'm	ATTO	Territoria de la companya della companya della companya de la companya della comp					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WIENF /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner IOW If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** -56-Hours Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "naturel", or items 23e or 28e-f ehow treumatic event, the Madical Examinat must be notified at Director HIMOre 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 73.
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "na any injury or other treumatic event, If a Madia one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Norman E rei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 2 Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 04,28-04 Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility laughn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** e As BUCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4□Pregnant at time of death 5 Other (specify) the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed

Division of Vital Records, P.O. Box 68760

To the Hospitel or Attending within 24 hours a completely

this

Director:

death.

after

State Registrar

Be

Certification:

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 Tes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 🗌 Homicide

(Check only one)

1 Inpatient

28a. Date of Injury (Month, Day Year)

29c. License number 206260

1 ☐ Yes 2 ☐ No

Other:

28c. Injury at Work?

Eccertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 DOA

29d. Date signed (Month, Day, Year) April 21, 200K

Location (Street and Number or Rural Route Number, City or Town, State)

2 X No

28d. Describe how injury occurred

4 ☐ Nursing Home 5 ☐ Residence 6 Cother (Specify) 103 pr Ce

1 Yes

26. Place of Death (Check only one)

Birthplace (State or Foreign Country)

State, Zip Code)

Approximate Interval Between Onset and Death

ears

Year

Day

2 No

10d. Inside City Limits 1 ☐ Yes 2

No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charle St. Latto. Md 2020x 6BMC 6701

2. Registrar's Signature

APR 2 6 2004

investigation

6 Could not be determined



2 FR/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

		,	For State Registrar	State of Maryland / [	Department of He		ntal Hygien Reg. N	2004	12913
	Physicia		1. Decedent's Name (First, Middle, Last)	DANIEL	FAULKN		Date of Death	Dey Year 17, 2004	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give str	itan Hogpi	tal Kalt	ocation of Death	4	c. County of Death	
,	Funeral Director		5. Social Security Number  225-14-4525  Usual Residence of Decedent	7. Age (In yrs. la t bir	thday) If Under 1 Year Months Days Yrs.	Hours Min.	Date of Birth (Month, Day, Yea EPTEMBER 2	r) Count	ace (State or Foreign ry) INIA
141	deeth with the Maryland ime 23a or 28a-f ahow r must be rediffed at	ctor	10a. State 10b. County  MARYLAND N/A	10c. City, Tow	n or Location			10	d. Inside City Limits 1 ☑ Yes 2 ☐ No
1 KI	23a or 28	ral Dire	10e. Street and Number 604 WHITMI	ORE AVENUE	10f. Zip Code 2/2	216		Citizen of What Count	ry?
740	ō = =	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Mg Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	panic Origin? (Specify, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - America Black, White, e	tc.
9e 14	within 72 ho ene. then "netur	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	ring most of working		Kind of Business/Ind	USCHOOLS
( c		To Be Co	17. Father's Name (First, Middle, Last)  DANIEL	FAULKN	1	18. Mother's Name (F	irst, Middle, Maide		
	- 6501		19a. Informant's Name/Relationship (Type WYNONIA GREGOR)	9, Print) 196 1-WISE (DAUGHTE) 3/	Mailing Address (Street an	MILL CT	oute Number, City PERRY HAL	or Town, State, Zip (	Code) 11236
o di di di di di di di di di di di di di	Pege nent o ant: If		20a. Method of Disposition  1	moval from State cemeter	Disposition (Name of ry, crematory or other place)	1 .		Location - City or Tov	m, State S, MARYLAND
100	permit. Pe Departmer Important any injury		21. Signature of Funeral Service Licensee	Williams	22. Name and Address 303EPH H. 2140 N. FUL.	BROWN J.	ALTIMO	RE, MARYL	AND QIQI'I
•	Physician /Medical		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	linous 1	such as cardiac or re	spiratory arrest,	1	Approximate Interval Between Onset and Death
0260	examiner un and ial-transit	dlcai Examiner	Sequentially list conditions, france leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	)				
9 20 0	death certific	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)			23d. Date of deliver Month	y Day Year
0	w requires that the de been signed by the a should be detached for	ed by Ph	Part II. Other significant conditions contri	ibuting to death but not resulting in	n the underlying cause given	in Part I.		use contribute to the	
0000	The law recate has be page 2 sho	Complet					24a. Was an autopsy performed?	death?	sy findings available pletion of cause of
A Appropriate Description of With Description	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2  10  Hot  27. Manner of Death  1  Natural 5  Pending investigation  3  Suicide 6  Could not be determined		tpatient 3 DOA Other:  Time of 28c. Injury a Work?  M 1 Ye	at 28d.	5 Residence Describe how inju	and Number or Rural	Route Number,
4 5	To the Hospitel or A within 24 hours after To the Funeral Direct completely filled in by	edical Cer	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine	cian: To the best of my knowledge	, death occurred at the time	, date and place, and	due to the cause(	s) and manner as sta	ted.
	To the h within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner stated.	29c. License r		29d. D	ate signed (Month, D	ay, Year)
	7		30. Name and address of person who com	pleted cause of death (Item 23a) (D 3 2   N			- 12		MD 2121
	Sta Registr	4.000	31. Dite filed (Month, Day, Year) APR 2 6 2004	32. Registrar's Signature	porks	,			Westerfore Description

DHMH 17 Rev 1/2001

George Faulkner

			1 - For State Registrar	State of Maryland / De	partment of Health and ertificate of Death	Mental Hygiene	2004   29 L
	Physic	ian	Decedent's Name (First, Middle, Last	t)		2. Date of Death Month / Day	3. Time of Death
	/Medi		LOLA MAE FRANK			April 21	2004 7:45 AM
	Examir	ner	4a. Facility Name (If not institution, give  Manner Healt  5. Social Security Number 6. Se	thot Belair	4b. City, Town, or Location of Deat	H	county of Death HALFOCO
i.	Funeral Director			7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 75	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign Country) MARYLAND
	and we		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygliene.  If Item 27 is marked other than "natural", or Items 23a or 28e-f ahow or other treumatic event, the Medical Examinar must be notified at	tor	Maryland Harford		Harford County		1 ☐ Yes 2☐No
	or 28e	Director	10e. Street and Number		10f. Zip Code	10g. Citize	en of What Country?
	23a 23a	al	1801 Mountain Rd.		21085	U	SA
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>		4. Race - American Indian, Black, White, etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 TNo If Yes, Give	1 ☐ Yes 2 ☐ No Specify:		Specify: White
Ş	tural	edk	15. Decedent's Edu	Year or Dates:	redent's Usual Occupation		d of Business/Industry
215	hin 72 en •na Medil	piet	(Specify only highest grad	de completed) (Gir	re kind of work done during most of wor DO NOT use retired)	king	a or business/ridusity
21215-0036	filed within Hygiene. ether than	Completed	12 yrs.	N/A Hor	nemaker	Homer	making~Own Home
nd	be file	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maiden S	lumame)
Sla	2 should be and Mental 1s marked o	2	Merle E. Reed			M. Neerdter	
Maryland	d 2 st th and th and treun		19a. Informant's Name/Relationship (Ty Richard T. Frank		iling Address <i>(Street and N</i> um <i>ber</i> o <i>r R</i> u L Mountain Rd. Jop		
<u>6</u>	s 1 and 7 Health Item 27 other tr		20a. Method of Disposition	20b. Place of Disi	position (Name of		ation - City or Town, Stete
Ę	Pages nent of nnt: If Ik ury or o		XX Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Tellioval Irolli State Monologo	d M. G. Cem. 4-24		imore, Md.
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	600	22. Name and Address of Facility	assahn Funera	
	40 E E 9		6. J. Jasa	rahm	7401 Belair Rd. Ba	altimore Mar	
			snock, or near failure. List only or	lications that caused the death. Do not e ne cause on each line	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Advance	d Dement	a	Onset and Death
0	Examiner			Due to (or all a consequence of);			1. 1
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter of Jednyling Cause (Disease or injury	b. Due to (or as a consequence of):			
	be executed sician and burial-transit	Examiner	that initiated events	с.			
30,	e exe		resulting in death) Last	Due to (or as a consequence of):			
8760	ate y et	Physician/Medicai		d			
9 x	leath certifica attending ph I for use as t	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy			
Box	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)	230	d. Date of delivery  Month Day Year
P.0	that the de led by the a detached t	hys	9 □ Unknown	9□ Unknown			
	es the	by	Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?
oro	law requires that as been signed b 2 should be deta	eted	Advance	d Parkins	one Disease	1 Yes 2 1	No 3 Probably 4 □Unknown
Vital Records,	و څ و	Completed				autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>a</u>	(0	e Co	25. Was case referred to madical			performed?	death? 1 Yes 2 10
Ē	Physician: this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	th (Check only one)	
1 0	g Phys er this eral di		27. Manner of Death	28a. Date of Injury 28b. Time		ome 5 Residence 6 28d. Describe how injury o	
io	Attending Ir death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	M 1 Yes 2 No		
Division of	of or Attendater death after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Street and A City or Town, State)	Number or Rural Route Number,
Ц	spital ours a neral [		29a, Certifier 1/1 Certifying Phys	sician: To the best of my knowledge, dea	th occurred at the tree data.		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examir	ner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	and due to the cause(s) an red at the time, date and pla	ace, and due to the cause(s)
	To the To the Comp	ž	29b. Signature and title of pertifier		29c. License number	29d. Date s	signed (Month, Day, Year)
•		,	111		D19583	Apri	121,200V
	18		30. Name and address of person who con	impleted cause of death (Item 23a) (Type	Print) 8 Law	Street X	crdeen.
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	9	Maryla	21001
1 195	Sia Registr		APR 2 6 2004	General G	- 1		

			For State of Ma			Health and Me	ental Hygi	ene 200	4 12010
			Registrar		Certificate of			g. No.	· · · · · · · · · · · · · · · · · · ·
	Physic	an	1. Decedent's Name (First, Middle, Last)  DORIS M. GREEN				2. Date of Death Month	Day Year	3. Time of Death  1626 M
	/Medi		4a. Facility Name (If not institution, give street and number)		4b City Town	or Location of Death	07	4c. County of Deat	
	Examir	ier	UPPER CHESAPEAKE		BFIAN	R,MD		HARFO	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birth	nday) If Under 1 Year	If Under 24 Hrs. g	. Date of Birth	9 Birt	hplace (State or Foreign untry)
	Director		216-12-0525 10M 2XF	80 Y	rs. Months Days	Hours Min.	Month, Day, 9 / 2 2 / 1	923 Mar	yland
	pu &		Usual Residence of Decedent           10a, State         10b, County	10c. City, Town	or Location				10d. Inside City Limits
	fanyla fahor	5							1 Yes 2X No
	the N	ect	Maryland Harford  10e. Street and Number	£age	Wood  10f. Zip Code		10	g. Citizen of What Co	
	0036 hours after death with the Maryland turel', or Items 23s or 28s-f show at Examiliser, ust be realised at	Funeral Director	1301 D Clovervalley Way		21040	1		United St	
	death	nerg	11. Marital Status 12. Was Decedent E- Armed Forces?	ver in U.S.	13. Was Decedent of	Hispanic Origin? (Speci pan, Mexican, Puerto Ri	fy Yes or No-	14. Race - Ame	
	after or ite	正	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	•	1 ☐ Yes 2 🕱 No		can, etc.)	Black, White	e, etc. White
	DOG nours	d by	Year or Dates:					Specify: V	niice
	15-17 n 72 l	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	, 1	6b. Kind of Business/	ndustry
	withly ene.	mc.	Elementary/Secondary (0-12) College (1-4or 5+	-)	sembly line	,		glass & e	mbleme
	Hygin other	Ö	17. Father's Name (First, Middle, Last)	ubi	JOHN TAIL	18. Mother's Name (	First, Middle, Mi		IDICID
9	land be dental	To Be	William Gardner			Anna L. H	Plummer		Ç.
<u>ه</u>	Maryland 21215-0036 d 2 should be filed within 72 hours aft tith and Mental Hygiene. Z? Is marked other than "natural", or traumatic event, the Medical Exami		19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street	t and Number or Rural I	Route Number,	City or Town, State, Z	ip Code)
_	and and and and and and and and and and		Barbara L. Hastmann - daught					Maryland :	21085
4	Ore ges 1 of Hi or oth		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of to cemetery	Disposition (Name of , crematory or other pla	Dat	e 20	Oc. Location - City or	Fown, State
0	Fag ment tant: jury		`4 ☐ Donation 5 ☐ Other (Specify)	Loudon		ery April	27,04	Baltimore,	Maryland
23/04	Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show ampiriqury or other traumatic event, the Marical Examines 1 as the notified at once.		21. Signature of Funeral Service Licensee		22. Name and Addre	ess of Facility Hubb	ard Fur	neral Home	, Inc.
I	- 403 e o		23a. Part1. Enter the disease, or complications that caused the	ha death De sa	4107 Wilk	ens Avenue,	Baltin	nore, Mary	
N	- CEA 200		shock, or heart failure. List only one cause on each line				espiratory arres	St,	Approximate Interval Between Onset and Death
the same	Pnysician /Medical		disease or condition resulting in death)	ARBIA	L INFA	RCTION			
	Examiner		Due to (or as a	(TKn)	0 15 C	RCTION HEMIA			
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of	7.	/ [ /-///-/			
W	cuted nd ransif	Examiner	that initiated events	TIC	KETO AC	180515			
	e exe		resulting in death) Last Due to (or as a	consequence of	):				
7	68760, ificate be executed physician and as the burial-transit	edical	d. UROS	EPSIS					
3	X 6 certific ding p		IF FEMALE: 23c. If yes, outcome of	foregnancy	-				
Acos 3840	P.O. Box (that the death certified by the attending detached for use as	Physician/M	in the past 12 months?	☐ Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	·y		23d. Date of deli- Month	Day Year
0)	P.O. that the d	hysi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at the grade of						
ğ	s that the	by P	Part II. Other significant conditions contributing to death but	not resulting in t	the underlying cause given	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
9	cords, P						1 ☐ Yes	2 <b>™</b> No 3 □ Pro	bably 4 Donknown
	ecords, law requires ti as been signe	Completed					24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of
	The The page	E C					performe	ed? death?	2 □ No
8	Vital Recipion of the law certificate has rector, page 2	Be (	25. Was case referred to medical examiner?			26. Place of Death (6			
8	on of Vital Reding Physician: The land. Arter this certificate has funeral director, page 2	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient		allent 3 DOA			ce 6 □Other (Spec	ify)
Q	on of ling Phys	lon	27. Mann Death 1 latural 5 Pending (Month, Day)	Year) 28b. Tir	ury Wo	ryat 280 rk? ]Yes 2 □No	d. Describe how	injury occurred	
.0	Division  or Attending after death. Director: After	ficat	2 Accident investigation 3 Suicide 6 Could not be 288. Place of Injur	v - At home, farn	n, street, factory, office		Location (Stre	et and Number or Ru	ral Boute Number
-67	Div A after Dire	Certification;	4 Homicide determined 200. Place of Injury	(Specify)	ii, street, factory, office		City or Town,	State)	ar noute runiger,
Q	Divisio To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	alC	29a. Certifier 1 Certifying Physician: To the best of	my knowledge,	death occurred at the ti	me, date and place, and	due to the cau	se(s) and manner as	stated.
(—)	n 24 I n 24 I he Fu	edical	(Check only one) 2 Medical Examiner: On the basis of e and manner state	xamination and/	or investigation, in my o	opinion, death occurred	at the time, date	e and place, and due	to the cause(s)
	To the within To the comp	Σ	29b. Signature and title of certifier	1.	29c. Licens	se number	29d	I. Date signed (Month	Day, Year)
	<b>)</b>		Nawn M. Gennedy	- L'H		56010	0	14/23/0	4 1626
	10		30. Name and address of person who completed cause of dea	ath (Item 23a) (T	ype, Print)				
	V		DAWN M. KENNEDY-LITTO 31. Date filed (Month, Day, Year) 32/Registrar	E, GO	UPPER	CHESAPEA	KE M	EDICAL (	ENTER
	Sta Registi		APR 2 6 2004	, M. A	Sparks				
			11. 11 10 0 0 0 1 1 1 1 1 1 1 1 1 1 1 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** APRIL ELMA N. GRAY 0415 AM 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SAINT AGNES HEALTHLARE BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer)
JULY 5, 1918 Birthplace (State or Foreign Country)
 NC **Funeral** Days Hours 1□M 2₽F Yrs. Director 220-80-6482
Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director N/A 1 √Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 2805 RIGGS AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or iter ury or other traumatic event, the Medical Examinar Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify BLACK 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOMEMAKER 17. Father's Name (First, Middle, Last) UNIC 18. Mother's Name (First Middle Maiden Sumame) EVERHART FOREMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARRY GRAY/SON 1245 13TH ST., N.W. APT 509, WASHINGTON, D.C. 20005 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) KING MEM. PARK 4/30/2004 BALTO., MD 22 Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Si mature of Funeral Service Licensee 1701 LAURENS ST., BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
DAYS Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner SEPSIS 3 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of ARTERY DISEASE. CORONARY YEARS Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🔀 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Medical Certification: To 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation Diractor: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

10

State Registrar

within 24 hours a
To the Funeral C

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)

APR 2 6 2004

ALOK RUSTOGI, MD, 900 CATON AVENUE, BALTIMORE, MD 21229 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D59398.

29d. Date signed (Month, Dey, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 A A 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 8.05 AM HOLTSCHNEIDER JAMES APRILDY 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 11XM 2∏ F 57 218-46-5797 Aug. 12, 1946 Maryland Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County rthan "natural", or Itema 23a or 28a-f ahow the Medical Examinar is ust be notified at 1 ☐ Yes 2X No Baltimore MD Essex **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1579 Williams Ave. 21221 death 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 and 2 should be filed within 72 hours after 1 Yes 2500 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: SpecifyWhite Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) DollarTreeInc. 2yrs Retail Manager of Health and Mental Hygis fitem 27 is marked other tr other traumatic event, the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lucille James Jacob Holtschneider 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lily Anne Holtschneider 1579 Williams Ave. Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H ant: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or BayviewCrematory 4/28/04 Baltimore MD 22. Name and Address of Facility Connelly Funeral HomeofEssex 21. Signature of Funeral Service Licensee 300 MAce Ave. Baltimore MD 21221 onn 23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) unknown **Physician** 5-6-U /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Dije to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) P.0. 1 Yes 2 No 9 Unknown 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Yes 2 No 3 Probably 4 hknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 Yes 2 No of Vital | To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 VER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation rector: by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide hours after within 24 hours afte To the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 0018230 APRIL 24, 2004 30. Name and address of person who completed cause of death (ttem\_23a) (Type, Print) SAMARITAN HOSPITAL SHASH DHARAN Groc D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 6 2004 Registrar

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			For State	State of M	aryland / Dep	ertificate of	Health and r			004	12018
			State Registrar AMFND TTFM  1. Decedent's Name (First, Middle	#20b PER FH G	330 4/26/04 <del>/</del> 9	Hillicate of	Dealli	2. Date of De	Reg. No.	007	3. Time of Death
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fer d	3	Funeral	<ul><li>11. Marital Status</li><li>1X Never Married 2  Marr</li></ul>	12. Was Decedent Armed Forces? ied 1 □ Yes 22 □	No Is	If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	Rican, etc.)	F 14. F	Race - America Black, White, e	
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altimore, mit. Pages 1 ar partment of Hea	or of		20a. Method of Disposition  X☐XBurial 2 ☐ Cremation	3 □Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	(ce) 4/28	Pata 704	20c. Locatio	n - City or Tow	n, State
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Balt Permit.	any injury or other trau		21. Signature of Funeral Service I	Licensee	)	22. Name and Addre March F	/H West				
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			1 - For State Registrar	State of Maryland /		rtment of He			200	11. 1201
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiern 27 is marked other then *natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	ji	21. Signature of Funeral Service Licen		41,52	Name and Address		.824 Reis		
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S F	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Finat disease or condition resulting in death)	a. Due to (or as a consequence		the mode of dying,	such as cardiac or	respiratory arrest.		Approximate Interval Between Onset and Death Weeks
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Vital	r this certification	o Be	25. Was case referred to medical examiner?	Hospital:		Oth	3. Place of Death (			
5	r this raid	$\vdash \downarrow$	1 Yes 2 No	Inpatient 2 ER/Os	tpatient Time of	3 DOA Other:	4 Nursing Home			ocify)
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DIVISION	after death. Director: A	1ca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, fa	rm stree			f Loonting /Ctront		
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To the Use	within 24 hours after do the Funeral Direct  Completely filled in by	Me	29b. Signature and title of certifier	ME, MD				290. [	Date signed (Mont	h, Day, Year)
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		3	Decedent's Name (First, Middle, Last	st)				2. Date of Deat		Year	3. Time of Death
	Physici /Medic		ROLAND K. HENDI	ERSON		,			L7, 200		8:05A. M
	Examir	ner	4a. Facility Name (If not institution, give	street and number)			Location of Death	•	4c. County		
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	puq		Usual Residence of Decedent  10a. State 10b. County	10c (	ity, Town or Lo	ocation					Od. Inside City Limits
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36	irs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify	w. Whi	t o
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Baltimore,	8° = 5		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □		Place of Dispo cemetery, crei	sition (Name of matory or other plac	a) .	oril 20	20c. Location -	City or To	wn, State
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Вох	death certificate e attending phys od for use as the	Physiclan/Medl	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of	al death 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	te of deliver	ry Day Year
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ivis	al or Attendated after death Director:	rtifle	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		eet, factory, office	÷ 1	28f. Location (Str. City or Town,		er or Aural	Route Number,
	To the Hospital or within 24 hours after To the Funerel Director Completely filled in b		00- C-49 15 C-49 D								
	Hospital 24 hours a Funerel I	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exemone)	ysicien: To the best of my kn niner: On the basis of examin and makes stated.	ation and/or in	n occurred at the time vestigation, in my op-	e, date and place, a pinion, death occurr	and due to the ca ed at the time, da	use(s) and ma te and place, a	nner as sta and due to	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	$\langle \rangle$		29c. License	number	29	d. Date signed	(Month, D	lay, Year)
)			· William	in Varin	NO	P:	2540	6	pril (	9.	2004
	0.		30. Name and address of person who d						P	1	2004
	10		WILLIAM LAMM, M.D.  31. Date filed (Month, Day, Year)	47 VIRGINIA  32. Registrar's Sign		CUMBERI	AND, MD	21502			
	Sta Registr		ADD 9 G	2004 Les	M	Court ?					
			MEN 4 U	LUUT ANDREAS	1 55	S. S. S. S. S. S. S. S. S. S. S. S. S. S					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dav **Physician** 26, Harry Sydney Apri1 2004 7:48AM Kruger /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 2505 Amber Orchard Court Apt. 101 Arundel Odenton If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys 1X M 2□ F Yrs. April 15, Ýork Director 099-22-2780 74 New Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth end Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show any Injury or other treumstic event, the Medical Examinating Invated to notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Funeral Director Maryland Anne Arundel Odenton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2505 Amber Orchard Court Apt. 101 21113 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1X Yes 2 ☐ No If Yes, Give 1 □ Never Married 2 □ KMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator 3 yr Lumber Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ludwig Kruger Pauline Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin W. Kruger/ Son 847 Sunny Chapel Road Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State West Arundel Crematory 4/27/04 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 22. Name and Address of Fecility
Donaldson Funeral Home & Crematory, P.A. 21. Signatule of Funeral Service Licensee HOmas-M00957 uanita 1411 Annapolis Road Odenton, Maryland 21113 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequen Completed by Physician/Medical Examiner ettending physician and for use as the buriel-trensit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Dunknown 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? certificate has b lirector, pege 2 s 2 DONO 1 Yes 1 Yes 2 No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Sylesidence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA To the Hospital or Attending Physical Within 24 hours effer death.

To the Funeral Director: After this completely filled in by the funeral di 27 Manner of Death 28e. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) M 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Datiel Scelle IM 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State

**DHMH 16 Rev 6/95** 

Registrar

APR 2 6 2004

**ORIGINAL** 

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			1 - For Registrar		epartment of Health and I Certificate of Death	Mental Hygie	2004 1/9//
	Physici	an	1. Decedent's Name (First, Middle, La	Kells		2. Date of Death Month	Day Year 3. Time of Death
	/Medio		4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Death	April	22 2004 7:15a. <sup>M</sup> 4c. County of Death
			4982 Denmore Av		Baltimore		
	Funeral Director		5. Social Security Number 6. S 218-60-5747 Usual Residence of Decedent	The offer	nday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye)	9. Birthplace (State or Foreign Country)  MD
	ryland how		10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	he Ma	ecto	MD NA	Balti			1X Yes 2 □ No
	3a or 3	D	10e. Street and Number 4982 Denmore A	1770	10f. Zip Code 21215	10g.	. Citizen of What Country?
36	d within 72 hours after death with the Maryland Jene. Ir than "netural", or Itams 23a or 28a-f show If the Modical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2√2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S <sub>I</sub> if Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: Black
2-0	72 hou	eted	15. Decedent's Ed (Specify only highest gra	ducation 16a. I	Decedent's Usual Occupation 'Give kind of work done during most of work	168	b. Kind of Business/Industry
21215-0036	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		h. b. C vs. 3 . 3
<u>0</u>	at the	a	12th grade  17. Father's Name (First, Middle, Last)	<del>-</del>	ocial Worker  18. Mother's Nam	ne (First, Middle, Mai	tate of Maryland
/lan	d ta b e	m	Willie Kells		Lilae		
Maryland	2 sh and Is m	l li	19a. Informant's Name/Relationship (		Mailing Address (Street and Number or Ru		
	s 1 and if Health item 27 other tr		Rachel C. Nand 20a. Method of Disposition	ce-Daughter 49	82 Denmore Ave. Disposition (Name of	Baltimor Date 200	e Md 21215 : Location - City or Town, State
altimore,	permit. Pages 'Department of H Important: If ite any injury or ot		Magazian 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification )	Removal from State cemetery	crematory or other place) ion Cemetery 4/2		ltimore, MD
Salti	permit. Departmimports		21. Signature of Funeral Service Licer		22. Name and Address of Facility	J/O4 Da	ICIMOLE, ND
<u> </u>	20529		220 Part Ent the disease or com	K. Jones	March F/H West 4300 Wabash Ave of enter the mode of dying, such as cardiac	Baltim	ore Md 21215
	Pnysician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Dehyd at: Oue to (or as consequence of	):	or respiratory arrest,	Approximate Interval Between Onset and Death
	Lamino	e	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. <u>Intestinal</u> Cuato for as a consequence of	obstruction		
	cuted nd ransit	Examlner	that initiated events	· Ovarian	cance/		
8760,	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or as a consequence of	):		
687	ficate physics the t	edlcal		d			
О. Вох	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
<u>a</u>	w requires that the been signed by should be detact	þ	Part II. Other significant conditions of	ontributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Vital Records,		Completed				24a. Was an autopsy performed	
Zit.	sician certifi irector	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	Otto	h Check onl one	
o	<u>a</u> = a	-1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		atient 3 DOA 4 Nursing No	me sidence 28d. Describe how in	e 6 Other (Specify) njury occurred
Division	tal or Atten rs after deat el Director: ed in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	one)	ysician: To the best of my knowledge, cliner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
	To Con	Σ	29b. Signature and title of certifier	e, MD	29c. License number	29d. I	Date signed (Month, Day, Year)
Z.	01			completed cause of death (Item 23a) (Ty	una Printi	2	-20-07
	,			GO /	D003542 pp. Print aroline St sports	Bal	ito, mel
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 6 2004	32. Registrer's Signature	sporks		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Rodney Lloyd Klinefelter 20, April 2004 8:40 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1328 West Street Hampstead Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye **Funeral**  Birthplace (State or Foreign Country) 1**∑**M 2□F 214-66-7153 Yrs Director 48 Mar 18, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Exactiner must be notified at Hampstead Director 1 ☐ Yes 2 ☑ No Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 1328 West Street "naturel", or Items 23a 21074 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and 1 s marked other than "naturel", or Items 23 ant: If item 27 is marked other than "naturel", or Items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2x No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Paving & Excavating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Luther Lay Klinefelter, Sr. June Lucille Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other treu once. Audrey E. Klinefelter, wife 1328 West Street, Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 04/23/2004 Evergreen Memorial Finksburg, MD 21. Signature of Finaral Service Licensee M00723 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Il-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4 Pregnant at time of death Year 5 Other (specify) ed by the a 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Xes Completed 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 4 Nursing Home 1 Yes 1 Inpatient Certification; To 5 ☐ Assidence 6 ☐ Other (Specify) his 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. within 24 hours after death.

To the Funerel Director: A completely filled in by the fi 1 TYes 2 TNo investigation 6 Could not be determined 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) APR 2 6 2004 3 Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 7:58 **Physician** April 23, Beverly F. Keene /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Carroll Westminster Carroll Hospital Center 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🖾 F 215-30-8385 June 6, 1934 Maryland 69 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County itam 27 is marked other then "natural", or Itams 23a or 28a-f ahow other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 21 No Completed by Funeral Director Carroll Finksburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21048 U.S.A. 2100 Ridgemont Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. is 1 and 2 should be filed within 72 hours after in thealth and Mental Hygiene. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☑ Marned 1 ☐ Yes 2 ☒ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edith E. Woodland Frederick Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If item 27 is 2100 Ridgemont Drive Finksburg, MD 21058 Husband Gilbert Keene 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If eny injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 4/26/04 Elkridge , Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 Lus Ce con Eline Funeral Home 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final **Physician** afterin Disease Caronary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Po 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Completed by cen den 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 1 No certificete 1 Yes Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Medical Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation I Director: / 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after To the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) ERNESTO Mendos 686c Pode 12stminster 31. Date filed (Month, Day, Year) 82. Registrar's Signatur State Registrar APR 2 6 2004

State of Maryland / Department of Health and Mental Hygiene Rag. No 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 20, Day 004 **Physician** George Charles Knoll 4:25 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Meadows Retirement Community Baltimore Glen Arm If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 6. Sex 1 ☑ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 213-09-0997 Director June 6, Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show mingorient: If item 27 is marked other then "natural", or Items 23e or 28e-f show yinjury or other treumatic event, the Medical Eventher must be notified at any injury or other treumatic event, the Medical Eventher must be notified at any injury or other treumatic event. 10b. County Maryland
10e. Street and N 1 TYPS 2 NO Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11630 Glen Arm Road, Unit 12 21057 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No δ Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 end 2 should be fill ment of Health and Mental Hient: If item 27 is marked other. Be John Michael Knoll Clara 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11630 Glen Arm Road, Glen Arm, Maryland Mrs. Ruth S. Knoll (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 26, 20c. Location - City or Town, State Burial 2 Cremation 3 Removal Irom State \* 4 □Donation 5 □ Other (Specify) Parkwood Cemetery 2004 Baltimore, Maryland Chisholm Funeral Services of Dulaney Valley, P. 200 E. Padonia Road, Timonium, Maryland 21093 21. Signature of Fune al Service Licensee Brian T. 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Cerebrov as cular **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> wten 2 No elsease 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 D Natural 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 72 /2004 1) 30433 U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21204 BALTIMORE 6701 STREET M MAY MD N CHARLES 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 2 6 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 14:02 Apri 2004 /Medical institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death **Funeral**  Birthplace (State or Foreign Country) 1 M 2 X Davs Hours Director 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Examiner must be notified at Director 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Itams 23a Funeral Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 K If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 ö 1 ☐ Yes 2 ☐ No Completed by Specify: 3 Widowed 4 □ Divorced is marked other than "natural", 15. Decedent's Education ecify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life DO NOT use retired) chdary (0-12) College (1-4or 5+) es.501 irst, Middle, Last) 18. Mother's Name (First. 2 should be f and Mental I 19a, Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Numb State, Zip Code) 21133 permit. Pages 1 and 2 Department of Health at Important: If Item 27 is any injury or other trau Baltimore. Method of Disposition 20c. Location -Serial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** 3 days /Medical Due to (or as a consequence of): Examiner schemic Bowel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Volvulus physician and Due to (or as a consequence of): Box 68760, Physician/Medical The law requires that the death certificate the attending p use as IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Dav Year 5 Other (specify) Ö the detached 9 Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 24a. Was an autopsy performed certificate Vital 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) s after deam.
In Director: After this read of the funeral directors. P 1 Yes 2 No 1 Impatient 2 ER/Outpatient of 3 DOA 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funaral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Medical Doctor Res 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emily

DHMH 17 Rev 1/2001

State

Registrar

Joe

31. Date filed (Month, Day, Year)

**ORIGINAL** 

wolfe

Street Baltimore, MD 21287-9106

North

32. Registrar's Signature

600

APR 2 6 2004

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day S. PANSY LANDON 2004 /Medical 22, A ril 4:47 AM 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Alice Byrd Tawes Nursing Home Crisfield Somerset 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Days Min. 1 M 2CXF Hours Yrs. Director 81 218-16-7233 October 19, 1922 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner invast be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 1 No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5043 Manokin Road 21817 USA 11. Marital Status 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whita, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0020 1 ☐ Yes ŽŽNo Specify: White þ Specify: 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Clothing Elementary/Secondary (0-12) College (1-4or 5+) 8 Manufacturer Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Quinn Sterling Grace Cullen ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Richard Landon, Jr. (Son) P.O. Box 737 - Crisfield, Maryland 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Asbury Cemetery 4/25/04 | Crisfield, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mary Beth Bradshaw-Pruitt

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, Maryland 21817 **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ASCVD Examiner Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed be detached for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? WALDENSTROM'S 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown MACRO GLOBULENEMIA Completed by After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation within 24 hours efter death

To the Funeral Director: A
completely filled in by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Medical ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 48098 5 April 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, Maryland 21817 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 6 2004 Registrar

DHMH 16 Rev 6/95

				1 - For State Registrer		of Marylar		artment of H			Reg.	20	0 L	129	28
3		Physic	an	Decedent's Name (First, Middle						2. Date Mont	of Death h	Day	Year	3. Time of D	
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Z		death ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Decedent of Hi f Yes, specify Cuba	1222 ispanic Orig	in? (Specify Yes	or No-		State se - America		
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hersis		filed withi Hygiene. other then ent, the M	Be C	17. Father's Name (First, Middle, L	ast)		1101110	indict.	18. Mother	r's Name (First, M	iddle, Maid	Own ] en Sumar			
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	Maryland	d 2 should be filed within 72 h h and Mental Hyglene. 7 Is marked other then "netu treumatic event, I.a. Medicul		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	g Address (Street a	an <i>d Numb</i> er	r or Rural Route N	lumber, City	y or Town,	State, Zip	Code)	
honlotte				Wilbert Lewis	- Husbar			rthship F		Dundalk,					
40	ore	ges 1 and of Healt if item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	State 20b. I	Place of Dispo cemetery, cren	sition (Name of natory or other place	θ)	Date	20c.	Location -	City or Tov	wn, State	
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4	Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.		21. Signature of Fun-rul Service L	ensee	2 MAIN	15 Fr	. Name and Addres adley-Ash	s of Facility	latthews	Funer	al Ho	ome. I	ſnc	
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		atter atter	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live I	birth 2 Feta	Ideath 3	Ectopic pregnancy Other (specify)			1/1	23d. Dai Mo	e of deliver nth	y Day Yea	ır
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.\/	ā	tel or At s after d sl Direc sd in by	Certification:	4   Homicide	build	ing, etc. (Specif	y)			City or	Town, Sta	te)			1
kx		To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying (Check only one) Medical E	reminal: Ou tue b	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the time estigation, in my op	e, date and inion, death	place, and due to occurred at the ti	the cause( me, date ar	s) and ma nd place, a	nner as stai	ted. he cause(s)	
		To t To t	Σ	29b. Signature and title of certifier	1 +1	2		29c. License			29d. D	/	(Month, Da		
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				30. Name and address of person w	1 GB1	mc 6	781 /	Print) U. Char	les Si	t. Ba	Ho.	me	21	205	
		Sta Registr		31. Date filed (Month, Day, Year) APR 2 6 2		Registrar's Signa	ure	M.							

Ruth Lowery 04-2688 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

268	8		1 - For uppend Item#23a,27,28a-1,4fr ME (%30,26)	ortment of Health and M	lental Hygi	ene	
,			Registrar  1. Decedent's Name (First, Middle, Last)	fficate of Death	Reg		12929
_	Physic /Medi		Ruth Lowerx		Month April 1	Day Year	3. Time of Death  22:43 PM
1	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	22010
2	r		St. Agnes Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore  If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	NA	to a Cotato as Foreign
355	Funeral Director		218-56-1661 1□ M 2 F 53 Yrs.  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, ) Sept. 21	1450 Min	lace (State or Foreign
	leath with the Marylan ns 23e or 28e-f show must be notified	Director	Manyland 10b. County 10c. City, Town or Lo	Baltimore		1	0d. Inside ofty Limits 1 ☐ Yes 2 ☐ No
	h with ti		III Wedgewood Rd.	10f. Zip Code 2122_9	100	g. Citizen of What Coun	itry?
036	within 72 hours after death with the Maryland ene. then "neturel; or Itams 23e or 28e-f show he Medical Exerting round be rediffed at	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, a Specify: Black	an Indian, etc.
Maryland 21215-0036	75	Completed	15. Decedent's Education (Specify only highest grade completed)  Flementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)	ent's Usual Occupation kind of work done during most of worki ONGT use retired)	ing 16	Private	Ditty
yland	2 should be filed and Mental Hygi le marked other reumatic event, II	To Be C	17. Father's Name (First, Middle, Last)  Jack Lowery	18. Mother's Name Helena	(First, Middle, Ma	aiden Sumame)	V
	s 1 and 2 should f Health and Mer item 27 le marke other treumatic		Ezzard Hawkins-triend IIIL	g Address (Street and Number or Rura	Rd. Bay	City or Town, State, Zip	code) 2001
Baltimore,	Page nenl o ent: If ury or		'4 Donation 5 DOther (Specify) WH. Zion	Cemetery 42	2404 LC	and downe	wn, State Maryland
Ba	permit. Departr Importe any inj		I fun factor 35	Name and Address of Facility of A	e. Balli	more Mar	yland 2121
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	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				***
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ivis (	or Atte	rtific	3 ☐ Suicide 4 ☐ Hornicide  6 ★ Could not be determined  28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office 2	8f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Ce	29a. Certifier (Check only one)  29m dical Examiner: On the basis of examination and/or invegand manner stated.	occurred at the time, date and place, a	nd due to the save	e(s) and manner as sta and place, and due to t	4-4
	To the within To the comple	Med	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, D	ay, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, P	O.C.M.E.		April 19,	2004
			S. R. HOGAN	111 Penn Street,	Baltimo	re, Marylan	d 21201
	Sta Registi		31. Date filed (Month, Day, Year)  APR 2 6 2004	Soul i			

			For State Registrar	State of I	Maryland		artment rtificate			and M	lental Hy	-	200	L	12	930
			Decedent's Name (First, Middle,	Last)							2. Date of D Month	eath			3. Time o	of Death
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	Funeral			5. Sex 7. 1 ☐ M 2 🗶 F	Age (In yrs. I	ast birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min,	8. Date of B	lev. Year)	944	Counti	ace (State	or Foreign
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	yland		10a. State 10b. County		10c. City	, Town or Lo	cation							10	d. Inside C	ity Limits
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36	72 hours after death with the Maryland Inatural; or Items 23a or 28a-f show dical Evarilins must be notified at	Completed by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ld 1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2	No No	Specify:				Specify:	1.11a ±	4.	
8	hour	edt	15. Decedent's		3.	16a. Deced	ient's Usual	I Occupa	tion			16b K	ind of Busin	Whi		
15	n "na	piet	(Specify only highest	grade completed)		(Give	kind of wor OO NOT us	k done d	uring most	of worki	ing		imore		,	Publi
212	filed within Hygiene. other than " ent, the Me	mo;	Elementary/Secondary (0-12)	College (1-4d	Jr 5+)	Ed	ucato	r					hool		•	
D	al Hy l othe	Be	17. Father's Name (First, Middle, L.	ast)					18. Mother	r's Name	First, Middle	e, Maiden	Sumame)			
ylaı	2 should be and Mental 1s marked c	10	Jesse Peck							Ste	lla Car	rter				
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "naturat", or items 23a or 28a-f show other traumatic event, the Medical Evanther must be notified at		19a. Informant's Name/Relationshi			1	-				l Route Numi				Code)	
	1 and 2 Health Iem 27 I	1	Mr. Anthony Marc	chione, Ph.		6 Win			rt C		eysvill					
0	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation :		te C6	emetery, cren	natory or oti	her place					cation - Ci	•		
Baltimore,	permit. Pages Department of Important: If if any injury or c		' 4 □ Donation 5 ဩ Other (Sp.		Dula						/26/04					
Ba	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Service Li	If Du	8/	V.	1050	York	Road	i To	ck Tows	Mary	unera land	2120	ome, 04	Inc.
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caus nly one cause on each	sed the death n line.	. Do not ent	er the mode	of dying	, such as o	cardiac c	or respiratory	arre <i>s</i> t,		1	Approxima Interval Be	tween
	Pnysician	0.0	Immediate Cause (Final disease or condition	Colo	on Can	rev									Onset and	M UZ
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ience of):								1		
	_xummer	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to /or	as a consequ	anaa oft										
	ted nsit	Examine	cause. Enter Underlying	Due to (or	as a consequ	erice oi).										
	be executed sician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ence of):										
8760,	ate be ex hysician the burial	dical E		d												
687	tificate ig phys as the	edic		U												
Вох	andin use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregnar 2 □ Fetal		Ectopic pre	ananav					23d. Date o	f delivery	/	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ♣No		at time of de		Other (spe						Month	C	Day	Year
P.0	at the de by the a stached	hy	9 🗌 Unknown													
	The law requires that the tee has been signed by the bage 2 should be detached.	by	Part II. Other significant condition	s contributing to death	n but not resu	Iting in the ur	nderlying ca	use give	n in Part I.				ıse contribu			
ord	v require been si should t	ted									1	Yes 2	<b>₹</b> No 3[	Probab	bly 4 🗍	Unknown
Records,	e faw has b	Completed									24a. Was	psy	prio	r to comp	sy findings pletion of c	available ause of
H		S									pen 1 □ Yes	ormed? 2 ■No	dea 1 🗆	tn? Yes 2	□ No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only					_
ō	Phys r this ral di	. To	1 ☐ Yes 2 ♣ No 27. Manner of Death	l l linpa		ER/Outpatien 28b. Time of		-	4 🔲 1901	_	ne 5 Res 28d. Describe		6 Other (	(Specify)		
on	ding Ih. After funer	tion	1 Natural 5 Pending 2 Accident investiga		Day Year)	Injury	М	Sc. Injury Work 1 □ Y	? os 2 □ N				y coourrou			
Division	or Attending after death. Director: After in by the fune	ertification:	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place of	Injury - At hor	me, farm, str	eet, factory,	office			28f. Location	(Street and	d Number o	or Rural I	Route Nun	nber,
D		Cert	4 Homicide	building,	etc. (Specify,	)					City or To	wn, State,	)			
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical (	29a. Certifier Check only one) Certifying 2 Medical E	Physicien: To the be xeminer: On the basis and manner	st of my know of examinati	vledge, death ion and/or inv	occurred a	it the time in my op	e, date and inion, death	place, a	and due to the	cause(s) date and	and manne place, and	er as stat due to th	ted. he cause(s	5)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	DIRECT			29c.	License	number			29d. Dat	e signed (A	Aonth, Da	ay, Year)	
	- 3 - 0		Long a suntan		AL ON	COLOGY	(	)23	675			ADV	11 23	3,21	400	
	10		30. Name and address of person w	ho completed cause o		23a) (Type,	Print 0		Ralta	Man	a. MK		150			
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regi	strar's Signati		/	,	628	2	-1 56					
	Registi		APR 2	6 2004	Gener	~ K	1 1	pou	tes							

		For State Registrar	State of N	/larylar	nd / Depa	artment of rtificate of	Healtl	n and M	Mental Hy		•	1293	
Physicia /Medica	in	1. Decedent's Name (First, Middle, Last)  (M2ADY  MILES						2. Date of De Month AP 21 L		eath Day 20	Year	3. Time of Death	
Examine	er	4a. Facility Name (If not institution, give street and number)  Johns Hopkins Hospital				4b. City, Town, or Location of Death  Baltimore				4c. County of Death NA			
Funeral Director		5. Social Security Number 219-08-2438  Usual Residence of Decedent	1 □XM 2 □ F	Age (In yrs. 36	last birthday) Yrs.	If Under 1 Ye Months Day	ar If Und	ler 24 Hrs.	8. Date of Bir (Month, Da 10-27-	rth ay, Year) -67			
B Maryland a-f show		10a. State 10b. County 10c. City, Town or Location  Md. NA Baltimore									10d. Inside City Limits		
or Items 23s	Funeral Di	10e. Street and Number  2919 McElderry Street  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married   1 Yes 2 No   1 Yes 2				10f. Zip Code  21205  13. Was Decedent of Hispanic Origin? (Specify Yes or Nil Yes, specify Cuban, Mexican, Puerto Rican, etc.)							
hin 72 hours in "natural", Medical Exp	Completed by	3 ☐ Widowed 4 ☐ Divorced II Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  II Yes 2 ☒ No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						ing	Specify: Black  16b. Kind of Business/Industry				
be filed tal Hygi d other event.	Be	12th grade 17. Father's Name (First, Middle, La	Laborer 18. Mother's Na			ther's Name	ADSCOM ame (First, Middle, Maiden Sumame			nc.			
12 sho h and 7 is mu trauma	입	George  19a. Informant's Name/Relationshi  Sado, Millor		Mile	19b. Mailir	ng Address (Stre	et and Nun		al Route Numb	er, City or To		Code)	
Pages 1 and nent of Health int: If item 27 iry or other ti	12-	Sade Miles  20a. Method of Disposition  1 Description Succession  1 Donation 5 Other (Spe	Mothe  ☐Removal from State scify)	20b. F	lace of Dispo cometery, cren	sition (Name of natory or other p	lace)	4-27-	Date	20c. Location	Md. 2 on-City or To imore,		
permit. Pag Department Important: I any injury o once.	-	21. Signature of Funeral Service Li			22	Name and Add	ress of Fa	cility	Balt	imore, E. Nor	Md.	21202	
Physician /Medical		23a. Part1. Enter the disease, or coshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	PULMO	IINO. NARY	b. Do not ente	er the mode of d			or respiratory a	rrest.	CII Ave	Approximate Interval Between Onset and Death 3 Hours	
xaminer	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):  PANCYTOPENIA  Due to (or as a consequence of):									2 WEEKS	
iysician and ne burial-transit	CCI.	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consequence of):  HUMAN IMMUNODEFICIENCY VIRUS								-	2 WEEKS	
5 8		IF FEMALE: 23b. Was decedent pregnant 23c. Il yes, outcome of pregnancy							23d. Date ol delivery				
signed by the atte	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	the past 12 months?  ☐ Yes 2 ☐ No ☐ Unknown  ☐ Unknown  ☐ Unknown  ☐ Unknown  ☐ Unknown  ☐ Unknown  ☐ Unknown  ☐ Unknown  ☐ Unknown  ☐ Unknown  ☐ Unknown  ☐ Unknown  ☐ Unknown  ☐ Unknown  ☐ Unknown								Month Day Year		
be o	<u>ה</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use con 1 ☐ Yes 2 ☑ No											
ate has	e Completed	autopsy performed?							prior to con death? 1 Yes	osy findings available inpletion of cause of 22 No			
18 p	0	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending 2  Accident investigal	28a. Date of In (Month, D	28a. Date of Injury  28b. Time of Injury  (Month, Day Year)  28b. Time of Injury  M 1 Yes 2 No							Other <i>(Specify</i> urred	)	
SE E	) L	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determina	building, e	building, etc. (Specify)							(Street and Number or Rural Route Number, wn, State)		
thin 24 hou the Fune mpletely fil	edici	29a. Certifier (Check only one)  1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.							and due to	the cause(s)			
CO CO		I tun Sheely Red MD REG-000						29d. Date signed (Month, Day, Year)  APRIL 20 200H					
()		30. Name and address of person what was street and reference to the street of the stre	JOHNS HOPI	KING	ItOSPITA		-110	500 NC,	2FH NOL	FESTR	1	TIMORE MARYLAND 21287	
State Registra	·	31. Date filed (Month, Day, Year)	R 2 6 2004	rar's Signa		. Sheet	A P						

			1 _ For State	State of M		/ Depa	artment of He	alth and N	lental Hygi	ene			
			1 - State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last) 2. Date						Reg	1. No. Z U U	3. Time of Death		
ı	Physici	ian							Month	Day Ye	0:34 M		
	/Medio Examir		TODD ALAN MOSBY  4a. Facility Name (If not institution, give street and number)  4b.					MARCH 8, 2004  4b. City, Town, or Location of Death  4c. County of Death					
	Examin	iei						BALTIMORE					
	Funeral			6. Sex 7. A	ge (In yrs. la:	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, )	(0.25) 9.	Birthplace (State or Foreign		
	Director		236-21-0776	1 <b>)(</b> )(M 2□F	21	Yrs.	Months Days	Hours Min.	JULY 13.	1982 h	Birthplace (State or Foreign Country) IEST VIRGINIA		
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo		cation				10d, Inside City Limits			
	Maryli f sho	ō	WV BERKE	EY INWOO						1 ☐ Yes 2 📉 No			
	the 7288-	rec	10e. Street and Number				10f. Zip Code		100	. Citizen of Wha	t Country?		
	be filed within 72 hours after death with the Maryland tal Hyglene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	Funeral Director	60 SIR WASHING	ΓΟΝ STREET			25428	3		USA			
-	ems arm	ner	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S.	13. \	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Sp Mexican, Puerto	ecify Yes or No-		14. Race - American Indian, Black, White, etc.		
36	or It	y Fu	1 Never Married 2 Marrie	If Yes, Give	1 ☐ Yes 2 (□XNo If Yes, Give		WW	Specify:	r nouri, oto.,	Specify:	BLACK		
Ö	hours tural	To Be Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		tonilo Havel Ossussti							
15	in 72 in 72 in in in in in in in in in in in in in i		(Specify only highes	t grade completed)	(Give life.		lent's Usual Occupation kind of work done dur DO NOT use retired)	ring most of work	ing	b. Kind of Busine	ess/industry		
212	d within giene. rr than "		Elementary/Secondary (0-12)				STUDENT			EDU	CATION		
pu	be filed tal Hygi d other		17. Father's Name (First, Middle, L		•			8. Mother's Name	e (First, Middle, Ma				
ylai			WENDELL E. I	WENDELL E. MOSBY DAVIDA									
Baltimore, Maryland 21215-0036	C1 00 = 0		19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street and IR WASHING	d Number or Run	al Route Number, C	City or Town, Stat	te, Zip Code)		
e, l	1 and Health em 27 ther tr		DAVIDA MOSBY/MO	)   NEK	20b Plac		sition (Name of			c. Location - City			
nor	6 O		1 Ø Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		cen	netery, cren HOPE CE	natory or other place)	; March		MARTINSBU			
Ė	# 문문를 .		21. Signature of Funeral Service L			22	Name and Address	of Facility	2004				
ä	Department Department		BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, W 25402										
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
760, te be executed	Physician		Immediate Cause (Final disease or condition METABOLIC ACIDOSIS								Onset and Death 1 HOUR		
	/Medical Examiner		resulting in death)	Due to (or as a consequence of): PULSELESS ELECTRICAL ACTIVITY							ac utu		
		Examiner	Sequentially list conditions,	b	ELESS		28 MIN.						
	uted d ansit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	SYSTEMIC HYPOPERFUSION							UNKNOWN		
	exection and rial-tra	Exa	resulting in death) Łast	0,	a conseque								
	9 ys	lical	1	d. CARDIOGENIC SHOCK						UNKNOWN			
x 68	The law requires that the death certilica tie has been signed by the attending ph page 2 should be detached for use as it	Physician/Medl	IF FEMALE:	230 If you outcome									
Вох	attend tor us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)					23d. Date of c		delivery Day Year		
P.O.	that the de led by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown									
	res that igned b be deta	by Pt	Part II. Other significant condition	conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?			
Vital Records,	w require been sig should b	edt								1 ☐ Yes 為□No 3 ☐ Probably 4 ☐ Unknown			
ecc	has be	ple							24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of		
= E		Be Completed						performed? death? XX Yes 2 □ No 1 □ Yes XX No		1?			
Vita	ysician: Th is certificate director, pag		25. Was case referred to medical examiner?  Hospital:  26. Place of Death (Check only one)										
	Phys rthis raldii	5 1	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1/1/2 (Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred									
O	Attending Physician: r death. ector: Atter this certific by the funeral director,	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, Day Year) Injury Work?  Ition M 1 □ Yes 2 □ No  It be 28e. Place of Injury - At home, farm, street, factory, office 2									
Division of	M or Attendi after death. I Director: A d in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not determine						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Ö	Hospital or 44 hours afte Funeral Dir tely tilled in I	Cerr		4	building, etc. (Specify)								
	Hosp 24 hou Fune tely til	Medical									as stated. due to the cause(s)		
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: Atter thi completely lilled in by the funeral	Med	one) and manner stated.							Date signed (Month, Day, Year)			
	F>F0		· Mara	de STe	X	MD	R	E5-00	o A	ori/ 2.	3,2004		
	$\mathcal{C}$		30. Name and address of person v		1 11	3a) (Type, I	Print) + Q	14	M	1 /	21367		
	Sta	to	31. Date filed (Month, Day, Year)	600 N. N.	rar's Signatur	9/2	ces, 1291	1117018	11914	and	C/C0 /		
	Sta Registr		APR 2	37	Page -	At a	Carrie :		,				
				1		- 45	PAGE TO SERVICE STATE OF THE PAGE TO SERVICE						

		4	For State Registrar	State	of Marylan		artment o				giene Reg. No. 2	04	12933
			Decedent's Name (First, Middle, La	st)						2. Date of Dea	ath		3. Time of Death
	nysiciar Medica		Paul	Α.	Mikusau	skas				April 2	22, 200	4 Year	12:06 A M
	xamine		a. Facility Name (If not institution, giv	e street and no	um <i>ber)</i>		4b. City, Tov	wn, or Loca	tion of Death		4c. Count	y of Death	
			Gilchrist Cen		7 4 (1		Tov	wson	ndor OA Han			ltimo	
	neral ector		5. Social Security Number 6. S 214-16-3064	ex M 2□F	7. Age (In yrs. I				nder 24 Hrs. urs Min.	8. Date of Birt (Month Da Feb 19	y, Year) 1010	9. Birth Cor May	place (State or Foreign intry) 'Y l and
	CCLOI		Usual Residence of Decedent							TED ID	, 1010	Mai	yrana
Linglan Linglan	1		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
DO WE WE WE	office	20	Maryland N/A	٠		Baltim				·			XIXYes 2 □ No
April 22, 2004 <b>036</b> 12,004 M  ours after death with the Maryland	animer roust be neithed at	runeral Director	10e. Street and Number				10f. Zip Co				10g. Citizen of		intry?
2 - in the state of the state o	THE PARTY OF THE P	e a	3516 Old York Ro		cedent Ever in U.	S 13 V		218	ic Origin? (Spe	cify Yes or No.		S.A.	ican Indian.
orling	nirner		1 ☐ Never Married 2 ☐ Married	Armed F	orces?	1				cify Yes or No- Rican, etc.)	Bla	ick, White	
933 P	5 (S) (A)	2	3 X Widowed 4 □ Divorced	If Yes, G Year or I	2 \( \text{No} \) ive \( \frac{1}{2} \text{941-1} \) Dates:	946	1 □ Yes 2 □	No Spe	ecify:		Specil	<sup>y:</sup> Wh	ite
5 / S   15-00:	dical E	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed,	,	16a. Deced (Give	lent's Usual O kind of work d	ccupation lone during	most of working	ng	16b. Kind of B	usiness/Ir	ndustry
		<u> </u>	Elementary/Secondary (0-12)	College	(1-4or 5+)						Colf (	[mn].	wad
D B B B B B B B B B B B B B B B B B B B	int, it	3	17. Father's Name (First, Middle, Last)			carpe	nter, 1			(First, Middle,	Self-E		yea
ylan ylan Mental	ic eve	o ne	Anthony	Mikusa	auckac				dele	Gelgo			
47 <b>2</b> 45 5 5	any pilury or other treumetic event, the Monce.	- 1	19a. Informant's Name/Relationship (		uskus	19b. Mailin	g Address (St				r, City or Town,	, State, Zi	p Code)
M. Mand 2	ar tra		Sean Bray Gr	andson		1 Co	rmer Co	ourt	#101	Timoniu	ım, Mary	/land	21093
Baltimore,	oth	1	20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐	Demoval from		lace of Dispo	sition (Name o	of r place)		ate	20c. Location		
Baltimo	o Aun		'4 Donation 5 Other (Specif	/)	Hil	ltop S	ervice	Corp	. 4-23	-2004	Towsor	n M	lary 1 and
Salt separt	any inj		21. Signaline of Puneral Service Licer	1500		22	. Name and A	ddress of F	acility Ruc	k Towso	n Funer	ral H	ome, Inc.
Ca m 203	: 65 CA		lang of the	an_			050 Yor			-	larylano	1 21	204
		-	23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on	caused the death each line.	. Do not ente	er the mode of	dying, suc	h as cardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death
Physi	ician dical		Immediate Cause (Final disease or condition resulting in death)	a	LUI		MIC	eR					years
Exam				Due to	(or as a consequ	ience of):							0
EVITE 3		ŭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consequ	ience of):						-	
petri	rial-transit		cause. Enter Underlying Cause (Disease or injury that initiated events										
О,			resulting in death) Last	Due to	(or as a consequ	ience of);							
8760, rate be ex	letached for use as the burial-transit  Dhyscloign/Medical Evering	2	(	d									
Box 687 eath certificate	detached for use as t	20	IF FEMALE:										
. Boy death or	or us	a	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregnar birth 2 Petal	death 3 [	Ectopic pregn					ite of delive	ery Day Year
P.O. hat the de	ched	325	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Preg 9□ Unkr	nant at time of de nown	atn 5∟	Other (specify	y)					,
. P. that t	deta		Part II. Other significant conditions of	ontributing to c	death but not resu	ilting in the ur	iderlying cause	e given in F	Part I.	23e. Did to	bacco use cont	ribute to t	he cause of death?
ords, P.O requires that the	should be det	2								1 □ Y	es 2 🗆 No	3 Prot	pably 4 Unknown
ecol	page 2 should									24a. Was a		Were auto	ppsy findings available
<b>Vital Re</b> o sici <b>a</b> n: The lav	age 2	5								autop:	sy med?	prior to co death? 1 □ Yes	mpletion of cause of
ian:	actor, p	ע	25. Was case referred to medical examiner?					26. F	Place of Death	1 ☐ Yes Check only or	1	1 1 1 43	2010
of V hysic	I dire		1 Yes 2 No	Hospital: 1	Inpatient 2 E	ER/Outpatient	3 □ DOA	Other: 4	Nursing Hom	ne 5 ☐ Resid	ence 6 Oth	er (Specil	1) Hospice
VISION Of VITA Attending Physician: ar death.	unera	5	27. Manner of Death 1 Matural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury		Injury at Work?		8d. Describe h	ow injury occur	red	
isio ktendii death.	the f	2	2 Accident investigation 3 Suicide 6 Could not be					1 Tes	2 No	0/ 1 1/ /0			
Division of Vital Records, for Attending Physician: The law requires the after death.	ed in by the funeral		4 Homicide determined	build	e of Injury - At hor ling, etc. (Specify	me, tarm, stre	eet, factory, off	lice	2	City or Tow	reer and Numb n, State)	er or Hura	al Route Number,
spital nours	pellii o	2	29a. Certifier 1 Certifying Ph	ysician: To the	e best of my know	vledge, death	occurred at th	ne time, dat	te and place, a	nd due to the c	ause(s) and ma	nner as s	tated
Division  To the Hospital or Attend within 24 hours after division of the Funeral Director:	completely filled in by the funeral director, page  Modical Certification: To Be Com	2	(Check only 2 Medical Exan	liner: On the t	pasis of examinati nner stated.	ion and/or inv	estigation, in n	ny opinion,	death occurre	d at the time, d	late and place,	and due to	o the cause(s)
To the within	comp		29b. Signature and title of certifier	1	0			cense num		2	9d. Date signed	d (Month,	Day, Year)
			1 / Hoth	my Kr	lez.	ans	00	252	05		April	22	2, 2004
115			30. Name and address of person who	completed cau		23a) (Type, F	Print)	0	2 0	0-1	20	/ 3	- > - :
7	C) .		31. Date filed (Month, Day, Year)	y C:	SMC (3 Registrar's Signat	6701	N.C	und	es Jr.	sal	ro. ra	7 ~	12005
R	State egistrar			S.	Togistial's Signal	A	AND WAS SOL						
			APR 2 6 2004	1	/	1 1	Similar Company	5+ "					

			For State	State of	f Maryland		artment rtificate			ind M	ental Hy	giene /	2001	12021
			Registrar  1. Decedent's Name (First, Midd	le (ast)			illicate	OIL	Jeani		2. Date of Dea		. 0 0 .	3. Time of Death
	Physicia	_	Ruth	М.		O'Don	nell				Month April	23 Day 2	Year 2004	6:30 p <sup>M</sup>
>	/Medic Examin		4a. Facility Name (If not institution		nber)	O DOL		own, or	Location o	f Death			unty of Deal	
	LXdiiiii		Genesis Elder	care - Spa	Creek		An	napo	lis			Anı	ne Aru	nde1
	Funeral		5. Social Security Number		7. Age (In yrs. I	•	If Under 1 Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Biri	hplace (State or Foreign ountry)
	Director		577-48-9086	1 M 2 X	68	Yrs.					Aug. 9	, 1935	5 Was	hington, DC
	and		Usual Residence of Decedent  10a. State  10b. Count	/	10c. City	, Town or Lo	ocation							10d. Inside City Limits
	Many -1 she	to	MD Anne	Arundel	E	dgewat	er							1 □ Yes 🏋 🛱 No
	r 28a	Funeral Director	10e. Street and Number	munder		чдонас	10f. Zip (	Code				10g. Citizen	of What Co	ountry?
	th with	aD	121 Stewart D	rive				2103					USA	
	ems er me	ner	11. Marital Status	Armed Fo		S. 13.	Was Decede If Yes, speci	ent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto l	ecify Yes or No Rican, etc.)	- 14.	Race - Ame Black, Whit	erican Indian, e, etc.
36	s afte	by Fu	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes, Giv	2X No		1 ☐ Yes 2	<b>K</b> No	Specify:			Sp	ecify:	White
9	d within 72 hours after death with the Maryland jiene than "natural", or Items 23a or 28a-f show the Madical Examinal must be rediffed at	ed t		nt's Education	a(63.	16a. Dece	dent's Usual	Occupa	ation			16b. Kind	of Business	/Industry
215	on "na	plet	(Specify only high Elementary/Secondary (0-12)	est grade completed)  College (1	-4or 5+)	(Give life.	kind of worl DO NOT us	k done d e retired,	furing most )	t of workii	ng			
212	TI 'CO -	Completed	12	Conlege (	40.01,	Edit	or					Feder	cal Go	vernment
pu	be filed tal Hygi d other event, I	Be (	17. Father's Name (First, Middle								(First, Middle,		mame)	
<u>yla</u>	should be and Menta a markad umatic ev	은	James Patrick		, Sr.	405 14-11		(01			arie Du		Ctata	Zio Codol
Maryland 21215-0036	01 00 00 00		19a. Informant's Name/Relation			1					2.2			zip Code)
	s 1 and 2 f Health item 27 i		Terry O Donne 20a. Method of Disposition			lace of Dispo	osition (Nam	e of			cnold,			Town, State
lon I	Pages nent of int: if it		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (	3 □Removal from Specify)	State	<sub>emetery, cre</sub> dar Hi	-			4-29-	-2004	Suit1	Land,	мп
Baltimore,	그는만등	1	21. Signature of Funeral Service		//	2:	2. Name and	Addres	s of Facilit	V			Lana	TID .
ä	permi Depar Impor any ir		Datal	A Child	1	1	12 Ri	dge1	v Ave	enue.	Home, P Annap	olis.	MD 21	401
			23a. Part 1. Enter the disease, of shock, or heart failure. Lis	or complications that cat only one cause on e	aused the death	n. Do not en	ter the mode	of dying	g, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between
E	Pnysician		Immediate Cause (Final disease or condition	a	Cau	liac	A	416	MY	a.				Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):		1						
	Examine	ē	Sequentially list conditions,	b. — Due to	(or as a consequ	uence of):								1=
	ted nsit	in in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	(									
Ć,	te be executed ysician and ie burial-transit	Examin	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):								
760,	<u>a</u> × a	cal		d										
89	The law requires that the death certificate b the has been signed by the attending physic tage 2 should be detached for use as the b	Med	IF FEMALE:						nustra e i					
Вох	ath ce	lan/i	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	tcome of pregna pirth 2 Petal	Ideath 3[	⊒Ectopic pre					23d	. Date of de Month	livery Day Year
	that the de ed by the a detached f	Physician/M	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□ Pregr 9□ Unkn	nant at time of de own	eath 5	Other (spe	эспу)						
P.O.	es that tigned by		Part II. Other significant condi	tions contributing to d	eath byt not resi	ulting in the u	underlying ca	ause give	en in Part I.		23e. Did t	obacco use	contribute to	the cause of death?
rds	quires n sign	d by	Gerena	e the	filip	•					1 🗆 '	Yes 2□N	io 3□P	robably 44 Unknown
Records,	aw require s been sig 2 should b	Completed			1						24a. Was	an 2	4b. Were a	utopsy findings available completion of cause of
æ	The law te has page 2 s	E O									perfo	rmed?	death?	
Vital	yaician: The is certificate hadirector, page	Bec	25. Was case referred to medic							of Death	(Check only o	one)		
of V		2	1 ☐ Yes 2 🔀 No		Inpatient 2			-	412 110	_	me 5 Resi		. ,	cify)
	fe fe	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pend		of Injury oth, Day Year)	28b. Time o Injury	of 28	8c. Injun Work	yat k? Yes 2.∐l		28d. Describe	now injury o	ccurrea	
Division	Attending or death. ector: After by the fune	icat	3 ☐ Suicide 6 ☐ Coul		of Injury - At ho	ome, farm, st			103 2		28f. Location (	Street and N	lumber or R	ural Route Number,
Div	after Direction by	Certification:	4 Homicide deter	mined 289. Flace build	ing, etc. (Specif	y)					City or To	vn, State)		
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certify	ring Physician: To the	e best of my kno	wledge, dea	th occurred	at the tim	ne, date an	d place,	and due to the	cause(s) an	d manner a	s stated.
	he Ho in 24 he Fu pletel	Medical	one)		ner stated.	tion and/or ir				un occurr	ed at the time,			
	To t To t	Σ	29b. Signature and title of certif	ier			29c	License	e number	70			igned (Moni	h, Day, Year)
	10	)						לע	100	70				
			30. Name and address of person	A, M.D. 60	10 RIPG	ELYX	VE S	TE Z	31 A	NNP	trous	mo	214	01
	Sta Regist		31. Date filed (Month, Day, Yea APR 2 6 200	1) Server	Registrar's Signy	Rure	parks	/						

			1 - For State Registrar	State of Marylan	d / Department of h Certificate of		ental Hygien	ie 16.2004	1293
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last GLADYS ELIZ. 4a. Facility Name (If not institution, give	ABETH SI		or Location of Death	APN 2	Pay Year 20, 2094	3. Time of Death
	Funeral Director		5. Social Security Number 6. Se.			If Under 24 Hrs. 8	Date of Birth (Month, Day, Yea	r) Cour	place (State or Foreign ntry) CYLAND
	with the Maryland tor 28a-f show	Director	10a. State 10b. County  MARYLAND N/A  10e. Street and Number	B	y, Town or Location  ALTIMORE  10f. Zip Code	215		Citizen of What Cour	0d. Inside City Limits 1
9003	hours after death with the Maryland tural', or itams 23a or 28a-f show al Evantinet must be redified at	d by Funeral Director	3914 BROOK  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:				14. Race - Americ Black, White, Specify: BL	
d 21215-0036	be filed within 72 ho ital Hygiena. id other than "natui avant, the Medical	e Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired SECRET	during most of working	NE	Kind of Business/Ind	
Maryland	d 2 should be th and Mental ?7 is markad o traumatic ava	To Be	ALBERT 1  19a. Informant's Name/Relationship (Ty		NDERS  19b. Mailing Address (Street	RUTH	V.	WILLIA	
Baltimore, Ma	ges 1 an 1 of Heal If itam 2 or other		LARRY W. LOWEN  20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ F  1 □ Other (Specify)	(HUSBAND) Removal from State	3914 BROOKH lace of Disposition (Name of emetery, crematory or other place BUTUS MEMORIAL F	IILL RD, B.	ALTIMU e 20c. l	CRE, MD Location - City or To	21215 own, State
Balt	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licens		22. Name and Address SOSEPH H. 2140 N. FUS				
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line.  a	5 ho ck	ng, such as cardiac or r	espiratory arrest,	-	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	Ical Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence.  Due to (or as a consequence)					
P.O. Box 68	death certific e attending p id for use as f	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 Ectopic pregnancy			23d. Date of delive Month	ry Day Year
	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the underlying cause give	en in Part I.	1/	use contribute to th	e cause of death?
Vital Records,	The ate h	Completed	Diabetes 1 Hypertension	nellitus			24a. Was an autopsy performad?	prior to con	psy findings available apletion of cause of
Division of Vita	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No H  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	dospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA Other 28b. Time of Injury Work M 1	4 Indising Home		6 □Other (Specify	)
Divisi	To tha Hospital or Attending Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office	28f.	Location (Street al City or Town, State	nd Number or Rural e)	Route Number,
	To tha Hospi within 24 hour To tha Funar completely fill	edical	one) 2   Medical Examir	sician: To the best of my knowner: On the basis of examination and manner stated.	wledge, death occurred at the timion and/or investigation, in my op	pinion, death occurred	due to the cause(s at the time, date an	s) and manner as sta d place, and due to	ated. the cause(s)
)	To with	Σ	29b. Signature and title of certifier	(in H	29c. License	- 190Z	29d. Da	ate signed (Month, E	20DY
	20 Sta	te	30. Name and address of each who co	ompleted cause of de the litem	Sinai Hos	pital o	f 130/4	timore	
	Registr		APR 2 6 2004		Sperke				

			For State	State of Maryla	ind / Departm	ent of Health ar	nd Mental Hygi	ene 2004	12936
0		1	Registrar  1. Decedent's Name (First, Middle, Last	)	Certific	ate of Death	2. Date of Death	g. No.	3. Time of Death
4	Physici /Medic		BARRON	W. t	PARKER	2 SR.	ADVI &	Day 2004	930 PM
	Examir Funeral Director	er	4a. Facility Name (If not institution, give  Movy and 60;  5. Social Security Number  218-05-4509  Usual Residence of Decedent	neral Hos	pital B	ity, Town, or Location of I OLL TUNDY Eder 1 Year If Under 24 hs Days Hours	City	Year) 9. Birthpl	lece (State or Foreign try) RGINIA
	yland		10a. State 10b. County	10c. (	City, Town or Location		-	11	0d. Inside City Limits
	with the Maryland	Director		IA		BALTIMO		- <u>Y</u>	1 1 Yes 2 □ No
	th with the 23s or 2	Dire	10e. Street and Number	ERSTOWN	ROAD	Zip Code	215	g. Citizen of What Coun	1
36	s after dea or Itema	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Vidowed 4 Divorced	12. Was Decedent Ever in Amed Forces?  1 ★ Yes 2 ☐ No If Yes, Give Year or Dates:	U.S. 13. Was Do	ecedent of Hispanic Originspecify Cuban, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Americ Black, White, 6	
8	72 hours "natural"		15. Decedent's Edi	ucation	16a. Decedent's U	Jsual Occupation work done during most of	of working	6b. Kind of Business/Inc	dustry
Maryland 21215-0036		Completed	Elementary/Secondary (0-12)	Coflege (1-4or 5+)	life. DO NO	Tuse retired)  HANIST		Karlon	41
d 2	2 should be filed with and Mental Hygiene is marked other tha aumatic event, Inali	Be Co	17. Father's Name (First, Middle, Last)		7 1 1 1 1 1 1	18. Mother's	s Name (First, Middle, M	aiden Sumame)	9
ylar	ould be Mental Marked c	To B	WILLIAM	<i>F</i>	ARKER	EL	LA	WAR	NER
Mar			19a. Informant's Name/Relationship (T	(DAUGHTER	19b. Mailing Add	ress (Street and Number	or Hural Houte Number,	City or Town, State, Zip	21215
Se,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tru once.		20a. Method of Disposition  **Burial 2	20b	Place of Disposition cemetery, crematory	Name of or other place)	Date 2	Oc. Location - City or To	
Baltimore,	nit. Pages artment of ortant: If it injury or o		* 4 □ Donation 5 □ Other (Specify	G		FOREST O			6.7
Bal	permit. Departmingorta		21. Signature of Funeral Service Licens	Nu alla	59	and Address of Facility	BROWN.	JR. FUNEL	PAL HOME
	\$\vec{\pi}{2}_{q} = \vec{\pi}{2}		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the de	eath. Do not enter the	mode of dying, such as ca	ardiac or respiratory arre		Approximate Interval Between Onset and Death
	Physician		fmmediate Cause (Final disease or condition resulting in death)	a Acute R	ospinator	y Distre	255 5 yn	drome	Oliset and Death
	/Medical Examiner			Due to (or as a cons	sequerice of):				
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to for as a cons	sequence of):				
•	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. HSO vat	requence of):	eumonic	)		
8760,	cate be executed physician and the burial-transif	dicai E	(	d					
9	ertifica sing ph	/Med	IF FEMALE:	23c. If yes, outcome of pred	nancy			Old Date of deliver	
Box	Hospital or Attending Physician: The law requires that the death certific 4 hours after death. Funeral Director: After this certificate has been signed by the attending tell filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	in the past 12 months?  1 \sum Yes 2 \sum No	1 Live birth 2 Fr 4 Pregnant at time of	etal death 3 Ectop	ic pregnancy r (specify)		23d. Date of delive Month	Day Year
P.0.	that the ed by the detach	Phy	9 ☐ Unknown  Part II. Other significant conditions or		resulting in the underlyi	ng cause given in Part I.	23e. Did toba	acco use contribute to th	ne cause of death?
Vital Records,	quires tha n signed   uld be det	ed by					1 □ Ye	s 2 No 3 Prob	ably 4 Unknown
eco	e law requ has been je 2 should	Completed					24a. Was an autopsy	prior to cor	psy findings available mpletion of cause of
a R	ician: The certificate h rector, page							☑No 1 ☐ Yes	2□ No
	/aiciar s certif directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	Other	of Death (Check only one sing Home 5  Resider		v)
n of	ng Phya fter this uneral di	on: T	27. Manner of Beath 1 → Natural 5 → Pending	28a. Date of Injury (Month, Day Year		28c. Injury at Work?	28d. Describe how	w injury occurred	
Division of	uttendi death. ctor: A y the fu	licati	2 Accident investigation 3 Suicide 6 Could not be		t home, farm, street, fa	1 Yes 2 N	28f. Location (Str	eet and Number or Rura	al Route Number,
Οį	al or A s after al Direction	Certification:	4 Homicide	building, etc. (Spe	ecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town,	State)	
	To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, death occu lination and/or investiga	rred at the time, date and ition, in my opinion, death	place, and due to the ca occurred at the time, da	use(s) and manner as st te and place, and due to	tated. the cause(s)
	To the To the Complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License number	29	d. Date signed (Month,	Day, Year)
	, ,,,		) VVa			89501	0	4/22/0	4
	10+1		30. Name and address of person who	completed cause of death (I	Item 23a) (Type, Print)	Muldan	Coene	al Has	intio:
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	V.		- 11 U	7
	Regist	rar		L. Res	17 10000	102			

DHMH 17 Rev 1/2001

APR 2 6 2004

RUSSELL, PATRICIA 4.22.04 7:00PM

			. For St					Health and	-	_	ibie.	
			For State Registrar		(	Cer	tificate of	Death		Reg. No. 2 (	104	12937
Г	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	PATRICIA LOUISE RI 4a. Facility Name (If not institution, give street				Ab Ciby Tourn	or Location of Deat	APRIL	22, 2	OO4 y of Death	7:00 P. M
	Examin	er	GILCHRIST CENTER	and number)					1		LTIMO	
	Funeral		5. Social Security Number 6. Sex	_	(In yrs. last birth	nday)	If Under 1 Yea Months Days	r If Under 24 Hrs.	8. Date of Bird (Month, Da			place (State or Foreign intry)
П	Director		214-26-1540		74 Y	rs.	Months Days	nours Min.	6/9/19			ISYLVANTA
	land Sw		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Lo	cation					10d. Inside City Limits
	Mary -f sho	tor	MD BALTIMORE		PARK	(VI	LLE					1 ☐ Yes 2 🔀 No
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?
	ath wi		1774 WESTON AVENUE					1234		USA		
	er des	Funeral	A	/as Decedent E		13. V	Vas Decedent of Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Ra Bla	ce - Ameri ack, White,	can Indian, etc.
36	urs aft	by F	If	Yes 2 X Yes, Give Year or Dates:	,	1	☐ Yes 2☐ <b>X</b> No	Specify:		Speci	<sup>∱</sup> WHI1	Œ
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "naturel", or Items 23a or 28e-f show event, it. M. Jical Franical input ke notified at	ted	15. Decedent's Education (Specify only highest grade con	n no(atad)	16a. [	Deced	ent's Usual Occi	upation e during most of wor	kina	16b. Kind of E		
2	ithin in in in in in in in in in in in in i	Completed		college (1-4or 5-	-)	life. [	DO NOT use retir	ed)	Kirig	RADEBA	IICH F	T.OPTST
7	filed w Hygier othar th		12TH GRADE  17. Father's Name (First, Middle, Last)		CL	ÆR!	K	19 Mather's Nor	ne (First, Middle,			DOMEST
and		To Be	OTIS BAXTER						WESTERM		110)	
ary	2 should be and Mental is marked craumatic even	F	19a. Informant's Name/Relationship (Type, F	Print)	19b. I	Mailin	g Address (Stree	at and Number or Ru			, State, Zij	o Code)
	5 # 7 E		FRANCIS RUSSELL	HUSBA	AND 1	77	4 WESTON	I AVENUE	BALTIMO	RE, MD	2123	34
Baltimore,	90 = 5		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □ Remove	val from State	20b. Place of [ cemetery		sition (Name of natory or other pl		Date	20c. Location PHOENI		
를	t. Pag ntmeni ntent: njury		* 4 □ Donation 5 □ Other (Specify)		POPLAR				6/2004			
Ba Ba	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licensee	Huy		8	3521 LOC	ress of FacilityTHE CH RAVEN E	LVD. TO	WSON, M		ME, P.A. 286
Ť			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused t use on each line					or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence	).	Cance	R				year
	Examiner			200 10 (0) 43 4	consequence en	,						
Ц.,	ש יב	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of	):						
	and trans	Examiner	that initiated events c	Due to for an a	consequence of							
60,	icate be executed physician and s the burial-transit	cai E		Due to (or as a	Consequence or	).						
687	ficate g phys		d									
ŏ	The law requires that the death certifical tite has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med		yes, outcome o		2□	Ectopic pregnanc	214		23d. Da	ate of delive	ery
E	e deat he att	sicia	1 Tyes 2 No	Pregnant at t			Other (specify)			Mo	onth	Day Year
<u>т</u>	hat the de d by the a	Phy	9 ☐ Unknown 9  Part II. Other significant conditions contribu		not regulting in t	bo un	doshina oo yoo a	wan in Cart I	330 Did to	phases use sen	tributa to t	he cause of death?
Records,	signed to be det	d by	Faith. Other arginicant conditions contribu	ting to death but	. Hot resulting in t	ile uii	denying cause g	IVON IN FAILT.	1 <b>½</b>			pably 4 Dunknown
Ö	w requir been si should	ete							24a. Was	an 24h	Were auto	psy findings available
	The lav	Completed							autop perfor	med?	prior to con death?	mpletion of cause of
Vital		BeC	25. Was case referred to medical			_		26. Place of Dea	1 ☐ Yes th (Check only o	1	1 🗌 Yes	2   No
<u>~</u>	hysica his ca Il dirac	To	examiner? 1 ☐ Yes 2 X No Hospit	1 Unpatien		atient	JU DON		ome 5 Resid	ence 6 🗷 Oth	ner (Specif	in Huspice
n O	ling P	ion:	1 X Natural 5 ☐ Pending	a. Date of Injury (Month, Day	Year) 28b. Tir Inji	me of ury	28c. Inje		28d. Describe h	ow injury occur	red	,
Division of	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	e. Place of Injur	y - At home, farn	n. stre		Yes 2 □No	28f. Location (S	itreet and Numi	oer or Rura	l Route Number,
2	after after Dire	Certification	4 Homicide determined	building, etc.	(Specify)	.,	, idotory, omoc		City or Tow	n, State)		arribble resimbor,
	To the Hospital or Attanding Physician: within 24 hours after deals. To the Funerel Director Attan this cartifica completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) (Check only one) (Check only one)	On the basis of e	examination and/	or inv	estigation, in my	oninion death occu-	red at the time of	tota and niaca	and due to	the cauco(c)
	o the	Med	29b. Signature and title of certifier	and manner state			29c. Licen	se number	- 2	29d. Date signe	d (Month,	Day, Year)
	F>F0		M Anthony	Rile	y a come	0	02	2707		April	22,	2004
	18		30. Name and address of person who comple	ted cause of de	ath (Item 23a) (T	ype, F	Print) Charle	se number 5205 Les St. K	alto 1	ms Z	c 20	۶
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1	parks					
	Registr	ar	APR 2 6 ZUU4									

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 🔲 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 1020215 04/23, M.D. 601. South Union ave, Havedopace, mo 21078

3. Time of Death

4:45 A

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

Birthplace (State or Foreign Country)

Maryland

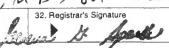
Year

State Registrar 31. Date filed (Month, Day, Yeer)

KARMA. S. NAIR

29b. Signature and title of certifier

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMC	Baltimo	permit. Page	Important: If
•		/N	ysiciar 1edica amine
	,160,	te be executed	ysician and ne burial-transit

		For State Registrar		S	tate of M	larylar			ent of H	lealth and Death	Mental H	ygien Reg. N	-00	04	1291
		Decedent's Nam	ne (First, Middle	, Last)				111101	410 07	Dodin	2. Date of D	Death		04	3. Time of Dea
hysicia/ Medic				Jo	hn Wes	ley s	Sauls,	Sr.			April		2004	Yeer 4	7:27 a
Examin		4a. Facility Name (		-		7)		4b. C	ity, Town, o	Location of Dea			c. County		
		Laurel							urel	T 1611 0.111-		_	Princ		
uneral rector		5. Social Security N 245-12-		6. Sex 1 <b>∑</b> M		ige ( <i>in yr</i> s. 81	last birthday) Yrs.	Monti	der 1 Year hs Days	If Under 24 Hrs Hours Min	. (Month, L	Day, Yea	7)	Cou	place (State or For
ector		Usual Residence of				01					sept	UI,_	1922	NOT	h Caroli
thow Tal	_	10a. State	10b. County			10c. Ci	ty, Town or Lo	cation							10d. Inside City Lie
	cto	MD	Princ	e Geo	rge	Col	lege F	ark				·			1⊠Yes 2□
N Or 2	by Funeral Director	10e. Street and Nu							Zip Code				itizen of V	Vhat Cou	ntry?
18 Z3	era	10107 5	Ist Ave		Was Deceden	t Ever in U	S 13		0740	ispanic Origin? (	Specify Yes or N		S.A.	e - Ameri	can Indian.
F F F	Fun	1 Never Man	ried 2 Marri	ed 1	Armed Forces	?   No		If Yes, s	specify Cuba	in, Mexican, Pue	to Rican, etc.)	•0-		k, White,	
E E	þ	3  Widowed	4 Divorced		f Yes, Give Year or Dates	1940	-46	1 🗌 Yes	2 X No	Specity:			Specify	whi.	te
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item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event. The Madical Examinar must ha notified at	mple	Elementary/Seco			College (1-4or	5+)	life.	DO NO	T use retired	1)	9				
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ed of	Be	Marcus	_							18. Mother's Na Essie		ie, Maide	n Sumam	10)	
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othe		20a. Method of Dis	sposition			20b. F	Place of Dispo	sition (	Name of		Date	_			own, Stete
7 o ==		1 🖾 Burial 2  1 4 □ Donation	☐ Cremation 5 ☐ Other (St		val from State	<del>3</del>	-	-			26.2004	Cro	พทรท	ille.	, Marylan
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Important: If ite sny injury or of once.		New	Hora.	M	_	M007	73 3	13 S	rason Talbot	t Ave.	ноте, л Laurel,	A. Mar	vland	207	07-4389
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sician		Immediate Cause disease or condition	(Final on		Sepsi										Onset and Death
dical niner		resulting in death)		("-	Due to (or a		uence of):								
- 14	h	Sequentially list co	onditions,	b	Renal										
ısıt	nine	Sequentially list contains to be cause. Enter Under Cause (Disease or	erlying r injury		Due to (or a	s a consuc	Heures of).								
burial-transit	Examiner	that initiated events resulting in death)	5	c.	Due to (or a	s a conseq	uence of):							-	
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the attending physic thed for use as the b	Physician/Medical	in the past 12 1 Yes 2 9 Unknown	2 months? □No		1 DLive birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3□		pregnancy (specify)				23d. Date Mor	e of delive nth	ory Day Year
		Part II. Other signi	ficant conditio	ns contribu	iting to death	but not res	ulting in the u	nderlyin	g cause give	en in Part I.	23e. Did	tobacco	use contr	ibute to th	ne cause of death?
ngis r	d b	Alzheime									1	Yes 2	2 □ No	3 🗌 Prob	ably 4 DUnkno
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page 2	Completed by										auto peri	opsy formed?	P	rior to cor	impletion of cause
certificate rector, pag	ပိ	25. Was case refer	rred to medical	1						26. Place of De	1 Tes		0 1	☐ Yes	2 No
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S =		27. Manner of Deal		2	8a. Date of Inj (Month, D		28b. Time of Injury		28c. Injury Work		28d. Describe				//
the fur	atlo	1 🖾 Natural 2 ☐ Accident	5 Pending investig	ation	(MOIIII, D	ay / Gai/	пцыу	М		res 2 □No					
Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could n determi		8e. Place of Ir building, e	ijury - At ho tc. <i>(Specif</i>	ome, farm, str	eet, fact	tory, office		28f. Location City or To	(Street a	nd Numbe e)	or Or Rura	l Route Number,
To the Funeral Direc completely filled in by	edicalC	29a. Certifier (Check only one)	1 Certifying	xamıner:	n: To the besi On the basis and manner s	of examina	wledge, death tion and/or inv	occurri vestigati	ed at the timion, in my op	e, date and place pinion, death occu	a, and due to the urred at the time	cause(s	s) and mar	nner as st	ated. the cause(s)
	ě l		d./fNe of certifier					- 2	29c. License	number		29d. Da	ate signed	(Month, I	Day, Year)
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comple	2	) i	8Au	16.	gireac			j	DAGE	0.0		-		-	204
To the Funeral of completely filled	2	30. Name and addi	18Acy	who comple	4/4cm	death (Iton	23a) /Tune	Print)	D425	80		Apr	il 2	3, 20	004

State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND FIFM #10e&19b FFR FH C831 5/28/04tilleate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sansbury Samue 1 Roland April 20 2004 1508 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 20,1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral XX**M 2□ F 81 Yrs. **Director** 219-12-3312 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Anne Arundel Lothian Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 350 B Street 20711 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 □ No If Yes, Give Year or Dates: WWTT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo þ Specify: White 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) Marine Construction 12 Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ages 1 and 2 should be fit nt of Health and Mental H t: If item 27 ie markad ott Hamilton Sansbury Louise Bowen 19a. Informant's Name/Relationship (Type, Print) 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth E. Sansbury (Wife) 350 B Street, Lothian, MD 20711 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If eny injury or once. \*4 Donation 5 Dother (Specify) Lakemont Mem. Gardens 4/23/2004 Davidsonville, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Hardesty Funeral Home, P.A. Daly 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebrorascular years /Medical Due to (or as a consequence of): Examiner A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit per terision signed by the attending physician and (o as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? rteral 1 Yes 2 No 3 Probably 4 Dunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2**□**No 1 ☐ Yes 2 ₽ No 1 ☐ Yes the Hospitel or Attending Physician: To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ို 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 060390 MO 2004 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adeeb Jahen, 100 HOSPITAL RD. Prince Frederick 20678 MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Day Kal APR 26 Registrar 2004

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

		1 - For State of Maryland /	Department of Health and Me Certificate of Death	Reg. No. 2004 1294
Physi /Med	cian dical	11 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -	ARD STAUBS	Date of Death Month Day Year 5:20 Am
Exam		NORTH ARUNDEL HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last E	4b. Cily, Town, or Location of Death CLEN BURNIE  Dirthday)  If Under 1 Year If Under 24 Hrs. 8.  Months Days Hours Min.	Ac. County of Death  ANNE ARUNDEL  Date of Birth (Month, Day, Year)  9 Birthplace (State or Foreign Country)
Directo	r	215-34-0913		Nov 24, 1936 Maryland
aryland show	2		wn or Location Pasadena	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
vith the Marylan or 28a-1 show	Directo	Maryland Anne Arundel,  10e. Street and Number  756 221st Street	10f. Zip Code 21122	10g. Citizen of What Country?
I or, Intally Italia Z I Z I O OOO OO OO OO OO OO OO OO OO OO OO O	by Funeral Director		13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
Ithin 72 hours le. san "naturel; IMedical Ex	Completed b		a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
lal y lallo Z   Z   Z   Z   Z   Z   Z   Z   Z   Z	Be Con	17. Father's Name (First, Middle, Last)	· ·	Baltimore Sunpapers First, Middle, Maiden Sumame)
2 should be and Mental Is marked or aumatic ever	2	Leroy Staubs  19a. Informant's Name/Relationship (Type, Print)  19	Blanch  9b. Mailing Address (Street and Number or Rural R	oute Number, City or Town, State, Zip Code)
G, Ma 1 and 2 s Health an em 27 is		Mrs. Bettejean Staubs (Wife)  20a. Method of Disposition 20b. Place	756 221st St., Pasade of Disposition (Name of Date	
Page nent o		1 D Burial 2 Cremation 3 Removal from State Cemet	on Park Cemetery 4/28/	and addition only of rown, dialo
permit. Departr		21 Signature of Funeral Service Licensee Kevin E Ecker	McCully-Polyniak Fu	neral Home, P.A. Pasadena, Md. 21122
Physiciai /Medica		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. SHOCK SEC.  Due to (or as a consequence	onot enter the mode of dying, such as cardiac or re	Approximate Interval Between
anth certificate be executed attending physicien and for use as the burial-transit	edicai Examiner	Sauentally list constant if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence cause. Due to (or as a consequence cause.	a of):	
To the Hospitel or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director. page 2 should be detached for use as the	Physician/Med!		th 3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year
uires that n signed b	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown
The law requirate has been single 2 should	Completed			24a. Was an autopsy autopsy performed? death?  1 Yes 2 No 124b. Were autopsy findings available prior to completion of cause of death?
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ding Phys	tion: To		A Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)  Describe how injury occurred
To the Hospitel or Attendii Within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, to building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospitel within 24 hours a To the Funerel completely filled	Medical C	29a. Certifier Certifying Physician: To the best of my knowledge	je, death occurred at the time, date and place, and nd/or investigation, in my opinion, death occurred a	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
To th Within To th	Me		29c. License number	29d. Date signed (Month, Day, Year)
10		30. Name and address of person who completed cause of death (Item 23a)	D 50055973 (Type, Print)	APRIL 24,2004
,	tate	31. Date filed (Month, Day, Year) 2. Registrar's Signature	and the way sur	ER SPRING MD 20904
Regis		31. Date filed (Month, Day, Year) APR 2 6 2004	grade	

DHMH 17 Rev 1/2001

				1 - For State Registrar	State of	Marylan	id / Depa		Health and N	•	giene	•	12943
				Decedent's Name (First, Middle, La	est)			inioato or	Death	2. Date of De	Reg. No.		3. Time of Death
	п	Physici	an		131)		THE	OFAR	doil	Month	Day	Year	
	-	/Media		JOHN			1.00			APRIL		2004	
	1	Examin	ıer	4a. Facility Name (If not institution, gire					or Location of Death			unty of Death	
				UPPER CHESAPE					362 ATM			ALFO	
	п	Funeral			Sex 7. 15∑M 2□F	Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birth	place (State or Foreign intry)
	н	Director		216-50-3040	.X	56	Yrs.			Sept. 2	29, 194	47 Mar	yland
		P 2		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Loc	ration					10d. Inside City Limits
		anyla sho	-	Tod. State				Allon					1 Yes 2 XNo
		88-f	ctc	Maryland   Harford	<u></u>	5	Street						
		or 2	Sire	10e. Street and Number				10f. Zip Code				of What Cou	
		23a	by Funeral Director	4525 Madonna Ro	oad			21154	Į.		Unite	ed Sta	tes
		dea dea	ne	11. Marital Status	12. Was Decede Armed Force	ent Ever in U	.S. 13. V	Vas Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	ecity Yes or No	o- 14.	Race - Ameri Black, White	
	9	or It	F	1 ☐ Never Married 2 ☐ Married	1 X Yes 2 If Yes, Give			☐ Yes 257 No				ecity: Whi	
	8	ours rai',	d b	3 ☐ Widowed 4 🂢 Divorced	Year or Date	s:		ZX	оровну.		Зре	WITT	
5	21215-0036	72 h	ete	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	ent's Usual Occup	oation during most of work	king	16b. Kind o	of Business/Ir	ndustry
7	7	ithin	npi	Elementary/Secondary (0-12)	College (1-4	or 5+)			during most of work d)	J	D4=====	D-	7
27.		should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural; or Items 23s or 28s-f show matic event. Its Madical Examinator right by instilled at	Be Completed	12			Prop	erty Mar					rt Admin.
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	la	Vent Ment Trke tice	2	Chris Terry					Evelyn	Elefthe	eriou		
	Maryland	2 should and Men is marks surnatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Number or Rui	al Route Numb	er, City or To	wn, State, Zij	Code)
6		and 2 ealth a m 27 is		Patricia Poole/F	riend		4525	Madonna	Rd. Stre	eet, MD	21154		
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ñ	9	Pages nent of i int: If it		1 ☐ Burial 2 XCremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci		110		sh. Crem.		3/2004	Laure	1. Mar	vland
4/20/04	altimore,	artme ortar		21. Ign rur of Fungal Service Lice	• •	Da.						-	
	Ba	permit. Pages Department of I Important: If its any injury or o		* Aux ( Fritz)	1 Limites	MOIIA.	2 Era	dley-Ash	ess of Facility nton-Mattl	news Fu	neral 1	Home,	Inc.
		_	7	2% Port Enter the disease or con	plications that cau	sed the deat	Do not ente	4 Willow	v Spring I	Road Ba	alt., I	MD 212	Approximate
_				23a. Phrt1. Enter the disease, or conshock, or heart failure. List only	one cause on eac				19, 30011 40 041 440	or reapmentary a	,,,		Interval Between Onset and Death
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		/Medical Examiner		Tooling in addition	Due to (or	as a conseq	uence of):						
-				Sequentially list conditions,	b								
h&bbC1	-	p ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a conseq	uence ot):						
39.		acute ind tran	E	that initiated events resulting in death) Last	c								
Ž	0,	be executed sician and burial-transit	Ē	resulting in death) cast	Due to (or	as a conseq	uence of):						
	68760,	ate be ex sysician be burial	icai		_ d								
m R#	99	eath certifical attending phy for use as th	Jed	IE ECAMIC.									
2	Box	endii use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy	,		23d.	Date of delive	ery
	Ω.	deat e att	Cia	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnan	t at time of d		Other (specify)	y 			Month	Day Year
	0	it the deby the tached	hys	9 Unknown	9⊡ Unknow	n							
	Д,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Med	Part II. Other significant conditions	contributing to deat	h but not res	ulting in the un	derlying cause giv	ren in Part I.	23e. Did t	obacco use c	ontribute to t	he cause of death?
1/2	rds	quire n sig uld b								1 🗆	Yes 2□No	3 Prot	oably 4 🛣 Unknown
	Record	w requir been s should	Completed							24a. Was	an 24	b. Were auto	ppsy findings available
C	Re	The lav	Ĕ							auto		prior to co death?	mpletion of cause of
oho.		ician: Th certificate ector, pag	C	00.144	1					1 Tes	3∕□ No	1 🗆 Yes	2DiNo
13	Vital	Physician: r this certifica ral director, p	80	25. Was case referred to medical examiner?	Hospital:			aCI DOA Oth	26. Place of Deat			-	-
<b>っ</b>	of	Phys this aldi	10	1 Yes 2 No 27. Manner of Death	1 🗆 Inp		R/Outpatient 28b. Time of	3 DOA	4   Industrig Fig				ý)
2		ding F h. After funera	o	1 Natural 5 Pending	28a. Date of I (Month,	Day Year)	Injury	28c. Injur Wor		28d. Describe	now injury oc	currea	
਼ਰ	Sic		cat	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ No				
F	Division	or Attencater death Director:	Certification:	4 Homicide determined	28e. Place of	Injury · At ho etc. (Specif	ome, farm, stre v)	et, factory, office		28f. Location (. City or To		mber or Rura	al Route Number,
91		ital curs al							1				
Theofanou		ths Hospital nin 24 hours a the Funeral I npletely filled	cai	(Check only 2. Medical Exa	hysician: To the be miner: On the basi	est of my kno s of examina	wledge, death tion and/or inv	occurred at the tire stigation, in my o	me, date and place,	and due to the red at the time.	cause(s) and	manner as s	tated. o the cause(s)
-			Medicai	one)	and manner	stated.							
		To To	-	29b. Signature and title of certifier	, ,		_	29c. Licens			29d. Date sig		
		/X\		yanishi r	41	M.	ار	1)	21809		APRIL	. 20	2004
		12,		30. Name and address of person who		of death (Item			_	,			. IF 2
					M ( D	233	-	214 (1	0 20	IMONI	v.n r	M D 2	210-12
		Sta Registr		31. Date filed (Month, Day, Year) APR 2 6 200	4 Z. Heg	istrar's Signa	Coos	les.					

			1 - For State Registrar		partment of Health and ertificate of Death		ene 2004 1	2944
			Decedent's Name (First, Middle, Last)	-		2. Date of Death	3. 1	Time of Death
	Physici /Medi		Michael Christopl	ner Vahaly		April	Day Year 2004 1	7:46 <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give street and it	number)	4b. City, Town, or Location of Deat		4c. County of Death	
			4887 Sykesville Road		Finksburg		Carroll	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)	) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Y	(ear) 9. Birthplace (	State or Foreign
	Director		004-34-9001	43 Yrs.		Mar. 9,	1961   New Yo	rk
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I	ocation		10d In	side City Limits
	Marylan f show	ō	Maryland Carroll	Finksbu	r o		1	∏Yes 2√∏No
	with the Maryland a or 28a-f show	Je.	10e, Street and Number	TIIKSDO	10f. Zip Code	100	g. Citizen of What Country?	A
	38 o	Funeral Director	2119 Bollinger Mill I	Road	21048		United States	
	death ms 23	nerg	11. Marital Status 12. Was De		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - American Inc	dian,
ဖွ	or ite	F.		s 2 X No		o Rican, etc.)	Black, White, etc.	
03	hours after tural, or ite	d by	3 Widowed 4 Divorced Year of	Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: white	
5-(	27	Completed	<ol> <li>Decedent's Education (Specify only highest grade complete)</li> </ol>	d) (Giv	edent's Usual Occupation  By kind of work done during most of work	king 16	6b. Kind of Business/Industry	
7	within ene. than "	du.	1.0	(1-4or 5+)	DO NOT use retired)		-	
2	Hygie ther int, II	ပိ	17. Father's Name (First, Middle, Last)	) (1	aims Adjuster	ne (First, Middle, Ma	Insurance	
Maryland 21215-0036	12 should be filed within hand Mental Hygiene. 7 is marked other than "Iraumatic event, Ira Med	To Be	William Scott	: Vaha		Ann	Kohut	<b>+</b>
ary	shou nd M mar	-	19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or Ru			
	nd 2 alth a 27 is		Mrs. Barbara A. Bearzi (					
ē,	item othe		20a. Method of Disposition	20b. Place of Disp	osition (Name of	Date 20	c. Location - City or Town, St	
E	Page net c		1 Marial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify) □ □ □	n State	Memorial Gdns. 20	il 24,	imonium, Maryl	land
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a gnce.		21. Signature of Fune at Service Licensee	The state of the s	2. Name and Address of Facility Shoim Funeral Ser			
8	9 9 5 8 8		7/1/	BIIGH I. OH	200 E. Padonia Ro	vices or r ad. Timoni	ium. Marvland	21093
			28. Far1. Enter the disease, or complications tha shock, or heart failure. List only one cause or	t caused the death. Do not en	iter the mode of dying, such as cardiac	or respiratory arrest	Appro	oximate val Between
	Physician		Immediate Cause (Final disease or condition	Multiple ?	injuries			t and Death
	/Medical		resulting in death)	o (or as a consequence of):	- J			
	Examiner		Sequentially list conditions. b					
	sit sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	o (or as a consequence of):				
	and and I-tran	Examin		o (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	alE		o (or as a solidayasiles si).			1.0	
587	ficate phys s the	edical	d					
Вох	eath certific attending p	Z/M	IF FEMALE: 23c. If yes, of	utcome of pregnancy			23d. Date of delivery	
ğ	death certifi e attending d for use as	Physician/M	in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)		Month Day	Year
0		hys	9 ☐ Unknown 9 ☐ Unk	nown				
S, P	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions contributing to	death but not resulting in the i	inderlying cause given in Part I.	23e. Did tobac	co use contribute to the caus	se of death?
ğ	w require been sig should b	ed				1 🗆 Yes	2 X No 3 ☐ Probably	4 Unknown
Records,	aw as b 2 si	Completed				24a. Was an autopsy	24b. Were autopsy find	dings available
-	Page 1	Com				performed		
Vital	ysician: The is certificete director, pag	Be (	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)		
of \	S S	ို	1XX es 2 No Hospital: 1 □	Inpatient 2 ER/Outpatie		ome 5 Residenc	e 6 Vether (Specify) S	CENE
		on:	1 Natural 5 Pending (Mo	e of Injury onth, Day Year) 28b. Time of Injury	Work?	28d. Describe how	injury occurred motor vehile u	chich
isio	ten feat for: the	Icat	a Could not be	4-21-04 Found 5:1		struck	a fixed obje	<i>x</i> +
	in the	Certification;	determined 200. Flat	ce of Injury - At home, farm, st ding, etc. (Specify)	1	City or Town, S	t and Number or Rural Route State) 4887 Sy Kesi	ville Rd
_	ospital or A hours after uneral Dire ly filled in by		29a. Certifier 1 ☐ Certifying Physician: To t	Roa	h occurred at the time, date and place,	Finksbur	of mo	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only XMedical Examiner: On the	basis of examination and/or in nner stated.	n occurred at the time, date and place, westigation, in my opinion, death occur	red at the time, date	e(s) and manner as stated. and place, and due to the ca	use(s)
	To th Within To the	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Ye	ear)
)	1		Mi Ki. m	()	O.C.M.E.		pril 22. 2004	
	h		30. Name and address of person who completed cal			21	22. 2004	
			LING LI. MID		Penn Street, Balt	imore, Mar	ryland 21201	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 6 2004	Registrar's Signature	E			

			1 - For State Registrar		of Marylar		artmen rtificate			ind M	ental Hy	/giene	2001	12945
	Physic	an	Decedent's Name (First, Midd	le, Last)							2. Date of De Month	eath Da	y Year	3. Time of Death
	/Medi		Stephen	George	Walker						_	23,	2004	11:20 A M
	Examir	ner	4a. Facility Name (If not institution						Location of	f Death		40	. County of Death	1
	- Francis		St. John Com 5. Social Security Number	Munity Ce	7. Age (In yrs.	last high day	Bal If Under	timo:	CE If Under 2	04 Hrs	8. Date of Bi		n/a	-1- (0)
	Funeral Director	1	219-38-0655	1 <b>⊠</b> M 2□ F	64	Yrs.	Months	Days	Hours	Min.	(Month, D.	ay, Year)	1 D / D M	nplace (State or Foreign untry)
	p .		Usual Residence of Decedent				1				March	20,	1340 11	aryland
	ahow	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	88-1	Director	Md. Balt:	rwore	Ba	ltimor	<b>.</b> 6							1 ☐ Yes 2 ☐ No
	with th	吉	10e. Street and Number				10f. Zip					10g. Cit	tizen of What Cou	untry?
	s 23	eral	1633 Jeffers		edent Ever in U.	6 12		1204	04-	:-2 /0			USA	
	fter d	Funeral	1 Never Married 2 Mar	Armed Fo	orces?	3. 13,	f Yes, spec	fy Cuban	n, Mexican,	, Puerto R	ify Yes or No lican, etc.)	0-	14. Race - Amer Black, White	etc.
93	ours after death with the Maryla ral', or Items 23a or 28e-f ahov Exulret : ust be rediffed at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes Gi	ive		1 ☐ Yes 2	No D	Specify:				Specify: Whi	te
5-0	72 hc	Completed	15. Deceder	nt's Education est grade completed)		(Give	dent's Usua kind of wor	4 dono de	inna most	of workin	2	16b. K	ind of Business/li	ndustry
7	within jene.	ld m	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT us	e retired)	371119 111001	or working	9	_		
2	77		12 17. Father's Name (First, Middle,	+2		Merc	hant (			de Nome	/Fire Additional		ansporta	ition
and	be at a be	Be c									(First, Middle		Sumame)	
Maryland 21215-0036	d 2 should be th and Mental 7 Is marked of traumatic ever	ဥ	John F. Walk  19a. Informant's Name/Relations			19b. Mailir	a Address	(Street au	d Number	rtruc	de Sm	ith er City o	or Town, State, Zi	n Code)
	d 2 F 7 L F a T a T a T a T a T a T a T a T a T a		Lynnallen Hughe	es/ Sister							on, Mc			,
Je,	of Health item 27 other tr	Ì	20a. Method of Disposition		20b. P	lace of Dispo emetery, crer	sition (Nam	e of		Da			ocation - City or T	own, State
E	Page nent c int: If		1 Burial 2 ☐ Cremation  '4 ☐ Donation 5 ☐ Other (S		SIZIA	raine				-27-	04	Woo	dlawn, M	Md.
Baltimore,	permit. Pages I Department of I Important: If ite any injury or ot		21. Signature of Funeral Service	Licensee			Name and				Home,	Inc		
	\$		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that o	ceused the death	n. Do not ent	er the mode	OFK of dying,	K□ . I , such as c	ardiac or	respiratory a	rrest,	<del>2U4</del>	Approximate Interval Between
La.	Physician		Immediate Cause (Final disease or condition	only one cause on e	20-2	Scleo	4	VAR	alen	- DG	وم م	_		Onset and Death
	/Medical		resulting in death)	Due to	(or as a consequ						ev =			-
	Examiner		Sequentially list conditions,	b										
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consequ	uence of]:								
	and and al-trar	xan	that initiated events resulting in death) Last	c	(or as a consequ	uence of):								
8760,	icate be executed physician and s the burial-transit	dical E				,								
687	ficate g phy: as the	edic		0.										
Вох	death certificate be executed e attending physician and id for use as the burial-transi	an/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		le						23d. Date of deliv	rery
œ.		sicla	in the past 12 months? 1 ☐ Yes 2 No		oirth 2 ☐ Fetal nant at time of de		Ectopic pre Other (spe						Month	Day Year
P.0	that the de ed by the detached	Physic	9 □ Unknown											
Ś	Se Union	by	Part II. Other significant condition  Plabets Y					use giver	n in Part I.					the cause of death?
010	w require been sig	eted	7 ( 2000 )	, ,	vacion	ouse	my				10	Yes 2	No 3□Pro	bably 4 Unknown
Vital Record	aw s b	Completed									24a. Was autor	psy	prior to co	opsy findings available ompletion of cause of
E	ate pag										1 Yes	ormed? 2 <b>25</b> No	death? 1 ☐ Yes	2MNo
<u> </u>	Physician: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:							Check onl			
of	Phys r this ral di	- To	1 ☐ Yes 2 😿 No 27. Manner of Death	28a. Date	Inpatient 2 1	ER/Outpatien 28b. Time of		le Injury a	'4∭X Nurs at		d. Describe		6 Other (Speci	fy)
OU	ding th. : Afte fune	ţ	1 XNatural 5 ☐ Pendin 2 ☐ Accident investi	g (Mon	th, Day Year)	Injury	М	lc. Injury a Work?	es 2∐N			The transport	, 55541154	
Division	I or Attending Phater death. Director: After th I in by the funeral	ertification:	3 Suicide 6 Could	ined 286. Place	of Injury - At ho	me, farm, str	et, factory,	office		28	f. Location (	Street an	d Number or Run	al Route Number,
É	spital or Al ours after o leral Directilled in by	Cert	4 🗆 Homicide	pullai	ing, etc. ( <i>Specif</i> y	")					City or To	wn, State	)	
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in 1	edical (	29a. Certifier 1 Certifyin (Check only one) 1 Medical	ng Physicien: To the Exeminer: On the ba	a best of my know asis of examinat ner stated.	wledge, death ion and/or inv	occurred a restigation,	t the time in my opi	, date and nion, death	place, an	d due to the l at the time,	cause(s) date and	and manner as s place, and due t	tated. the cause(s)
	withir To th Comp	Me	29b. Signature and title of certifie				29c.	License	number			29d. Dat	e signed (Month,	Day, Year)
			PR.t. Tu	bert, in	).			Da	146,	<u>~</u>		5	1/23104	
2	141		30. Name and address of person	who completed caus	se of death (Item	23a) (Type,	Print)							
_	TI'		ROBERT LIBERTO	, NO. 350	OF BAN	とらナ	BM	NI, 1	rul	21.	224			
	Sta	-	31. Date filed (Month, Day, Year)	32. R	legistrar's Signat	ture &	/		•					
	Registr	वर	APR 2 6	ZUU4   A	and and	Ø	600	eks-	19 "					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last) A Month 2. Date of Death 7; UOM **Physician** Yeer + ar101 2000 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Mercy Baltimore cater NA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10-15-31 Birthplece (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours 215-28-1580 Yrs. Director S.C Usuel Residence of Decedent 10a. State 10b. County 7 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar count be notified at 10c. City. Town or Location 10d. Inside City Limits Director Yes 2 □ No Md. NA <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 818 Brooks Lane 21217 death USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give X
Year or Dates: 1 Never Married 2 Married
3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Black Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. snt: If Item 27 Is marked other then "ury or other traumatic event, traums. Elementary/Secondary (0-12) College (1-4or 5+) Machinist Alban Tractor 3rd grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas White, Sr. Hattie Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurine C. White Wife 818 Brooks Lane, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Donation 5 Other (Specify) permit. Page Department of Important: If eny injury or once. Loudon Park Cem. 4-26-04 4-26-04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 2 1101 E. North Ave. 21202 ladys Wane March F.H. East Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Mo Ca/ /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit I or Attending Physician: The law requires that the death certificate <u>pa-executed</u> affect death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetel dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date 28b. Time of 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signative and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 00 30. Name and address of person who completed call se of death (Item 23a) (Type, Print) Place #815 13. Ho mil 21202

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

er

R 2 6 2004

MID

32. Registrar's Signature

				State of Maryla	nd / Dep		lealth and N	lental Hy	giene	_	12947
			Decedent's Name (First, Middle, Last)	**				2. Date of De	ath		3. Time of Death
	Physicia		Gwendolyn	Albright				Month MARCH	Day 2 9		4:30am M
	/Medic Examin		4e. Fecility Name (If not institution, give si			4b. City, Town, o	r Location of Death		4c.	County of Deeth	
		•	CTVTSTA_MEDICAL	CENTER		LA PI	LATA			CHARLES	S
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (in yr	s. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da June 3	$0^{\text{Year}}$	9. Birth Cou 920 K	place (State or Foreign ntry) entucky
	pue *		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or L	ocation					10d. Inside City Limits
	death with the Maryland rme 23s or 28s-f ehow r must be notified at	Director	MD None		Balti	more			10a Chi	zen of What Cou	1 ☐ Yes 2 No
1	23a or 2	ral Dir	10e. Street and Number 1539 Elrino St			2122				USA	
147	after dea or Iteme	Funeral	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	-	14. Race - Ameri Black, White	, etc.
A 10	hours at Example of Ex	ed by	Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	16a. Dece				16b. Ki	Specify:  Ind of Business/Ir	White
215	thin 72 8. An "na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)			pation during most of work d)	ing			
<b>₹</b> 2	filed with Hygiene ther the	Son	12			Homemake				Home	
Sull Nooly Alband 21215-0036	nit Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene. ortant: if item 23 or 28 or 28 or ehow inpury or other traumatic event, it is Medical Examinar must be notified at inpury or other traumatic event, it is Medical Examinar must be notified at 8.	To Be (	17. Father's Name (First, Middle, Last) David Akers				18. Mother's Nam Della			Akers	
//wah	nd 2 sho aith and h 27 ie ma r trauma		19a. Informant's Name/Relationship (Type Luther Albright		1		and Number or Run Lane, Wa				o Code)
	Hes item othe		20a. Method of Disposition	20b.	Place of Disp	osition (Name of matory or other plan		Date		cation - City or T	own, State
FINO	permit Pages 1 and 2 Department of Health s Important: if item 27 it any injury or other tra		1 X Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	W	loodla	wn Cemet	cery 4/5				,Maryland
Ball	Depart Import any in		21. Signature of Funeral Service License	hal )	45		r≟Echols X 567 l				
•	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	Neg	atme	sepsis	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events resulting in death) Last	Due to (or as a conse							
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes	Sc. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	ital death 3	□Ectopic pregnance □ Other (specify) _	у		2	23d. Date of deliv Month	rery Day Year
	w requires that s been signed b should be deta	þ	Part II. Other significent conditions con	tributing to death but not re	esulting in the	underlying cause giv	ven in Part I.	23e. Did to			the cause of death?" bably 4 Unknown
cor	law req as been 2 shou	Completed						24a. Was		24b. Were aut	opsy findings available ompletion of cause of
Re	icien: The Is certificate ha rector, page 2	mo						autor perfo	rmed?	death?	
tal	en: Tifica tor, p	0	25. Was case referred to medical				26. Place of Deal				
<u> </u>	SOT	To B	examiner? 1 Tes 2 No	ospital: 1/2/Inpatient 2	☐ ER/Outpatie	nt 3 DOA Ott	ner: 4 Nursing Ho	me 5 Resid	dence (	3 □Other (Speci	fy)
Division of Vital Records,	Jing After fune		27. Manner of Death 1/⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wa	yat rk? Yes 2 □ No	28d. Describe l	now injur	y occurred	
Divisi	if or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, s	treet, factory, office		28f. Location (S City or Tox	Street and vn, State	d Number or Rur )	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C		ician: To the best of my ker: On the basis of exami and manner stated.							
	To th within To th compl	Me	29b. Signature and title of certifier	ell M	<i>&gt;</i>	29c. Licens	se number $2289$			e signed (Month,	•
.۸.	Dia		30. Name and address of person who could NALIN MATHUR M		em 23a) (Type	S DRIVE	WALDORF	MARYI	AND	20603	,
- 1	Sta	te	31. Date filed (Month, Day, Year)	32. Registar's Sig	nature	back .					

			1 - For State Registrar	State of M	<b>1</b> arylar		artment of		and Menta		ne No. 2014	1201.0
	Physic		Decedent's Name (First, Middle, Las Kim Mar:		Ahlqı				2. Da	te of Death	1 <sup>Day</sup> 2004	3. Time of Death 1140 AM
	/Medi Examii		4a. Facility Name (If not institution, give			l	4b. City, Town		of Death		4c. County of Death	1. // 10 11
	Funeral Director		5. Social Security Number 6. Se			last birthday) Yrs.	If Under 1 Ye Months Day	ar If Unde	r 24 Hrs. 8. Da	te of Birth onth, Day, Ye	9. Birtho	elace (State or Foreign htry) Land
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show amy injury or other traumatic event, I'm Medical Exact at mast be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County  Maryland Calvert  10e. Street and Number  11549 Tomahawk Tra  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last) Hubert L. Norris  19a. Informant's Name/Relationship (7 Kerry Ahlquist - 1  20a. Method of Disposition  1 Burial 2 Cremation 3 Di 4 Donation 5 Other (Specify, 21). Signature of Furneral Service Licens	12. Was Deceden Armed Forces 1 □ Yes 2 Eyes, Give Year or Dates: Jucation Ge completed) College (1-4or	Lit Ever in U ? No	16a. Dece Give life. I homem 19b. Mailin 11549 Place of Dispo emetery, cren	I 10f. Zip Code 206  Nas Decedent of Yes, specify C I Yes 2 N I Ye	of Hispanic Ouban, Mexica lo Specify cupation and during movered)  18. Moth	st of working  oer's Name (First,  fune Mari  oer or Rural Route  til West  Date  1 12 200  ervice	Middle, Maidle Fle  Number, Cit  Lusby  200  A lex	Citizen of What Cour ited State  14. Race - Americ Black, White, Specify: Wh  b. Kind of Business/Inc OWN home den Sumame) tt  ty or Town, State, Zip Location - City or Tow Kandria Vi	es an Indian, etc. ite dustry  Code) wn, State
	cate be executed cate be executed beyond the circuit of the port of the purial-transit the burial-transit cate of the purial-transit lcal Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sulfactions that cause on each in a sulfaction of the cause on each in a sulfaction of the cause of the ca	a consequence of the	uence of):	er the mode of d	OTTO I	Rausch laryland scardiac or respir	20070	al Home	Approximate Interval Between Onset and Death Welks	
. Box 6	requires that the death certific teen signed by the attending p hould be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant conditions co	33c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal t time of de	death 3 ath 5	Ectopic pregnan Other (specify) derlying cause o		. 238	э. Did tobacc	23d. Date of deliver Month [	Day Year
al Records	The law ate has b	Completed	Anemia Hypertensin							1 Yes  a. Was an autopsy performed? Yes 2	24b. Were autop: prior to com death?	bly 4 Donknown sy findings available pletion of cause of
Division of Vital Record	ding Ph h. After th funeral	Certification; To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 Mpatri 28a. Date of Inju (Month, Da	iry	ER/Outpatient 28b. Time of Injury	28c. lnj	ther: 4□Nu	28d. Des	Residence	6 Other (Specify)	
Divi	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fr	edical Certific	4 Homicide determined  29a, Certifier 14 Certifying Physics	28e. Place of Inibuilding, et building, et sicien: To the best	of my know	vledge death	Occurred at the	time date an	d place, and due	to the sausai	and Number or Rural (te)  (s) and manner as stained place, and due to to	
	To the t within 24 To the F complete	Medi	29b. Signature and title of certifier	MD	1160.		29c. Licer	opinion, dea	an occurred at the		nd place, and due to to the place signed (Month, Da	
	Sta Registra		30. Name and address of berson who con Added Table 31. Date filed (Month, Day Year)  APR 1	32. Registr	10	0 H25	DITAL Spark	Nd.	Prince	Fred	erick, n	~ 2067B

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			1 - State Registrar			Cei	rtificate o	f Death		Reg. N	. 200	4 1291.	
~ :5:	m (8		1. Decedent's Name (First, Midd	fle, Last)					2. Date of			3. Time of Death	
	Physici /Medi		Jol	nn William	a An	drew			APRI	- 4	z OO 4	1 1855 M	
	Examir		4a. Facility Name (If not institution) サカビ MEMORIAL	HOSPITAL AT		TON	EA:	, or Location of D			c. County of Deal		
Sec.	Funeral Director		5. Social Security Number 218-16-5979	1₽M 2□F	ge (In yrs. Ia 80	Yrs.	If Under 1 Yea Months Day		vin. (Month,	Day, Yea.	9. Birthplace (State or Foreign Country)  Maryland		
	land Sw		Usual Residence of Decedent  10a. State 10b. Count	y	10c. City,	Town or Lo	cation					10d. Inside City Limits	
	Many f sh	jo	MD Dor	chester			Hurloc	k				1 ☐ Yes 2 ☐ No	
	r 28s	rec	10e. Street and Number				10f. Zip Code	)		10g. C	itizen of What Co		
	h with	D	5239 River	Road				21643		Uni	ted St	ates	
	deat	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	i. 13.	Was Decedent of		? (Specify Yes or luerto Rican, etc.)		14. Race - Ame	rican Indian,	
9	after or its	正	1 Never Married 2 Ma	rried 1 □ Yes 2 ☐			1 ⊡Yes 2√x N		derio nican, etc.)		Black, White		
8	ural',	d by	3 Widowed 4 Divorce	d Year or Dates:							Specify:	White	
15	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Exerciter must be routified at	lete	(Specify only high	nt's Education est grade completed)		(Give	dent's Usual Occ kind of work don DO NOT use reti	ne during most of	working	16b.	Kind of Business/	industry	
21215-0036	withi iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)			ree Exp	nart	A	rboris	t	
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Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28s-f show other traumatic avant, the Medical Exercities finest be notified at	To E	William E	. Andrew				Mary	Lolita	a C	hance		
lan	2 sho and I s ma		19a. Informant's Name/Relation						r Rural Route Num				
	and ealth m 27 har tr		Jean M. And	rew/Spouse				Road,	Hurloc!	-			
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or othar tr once.		20a. Method of Disposition 1   □ Burial 2 □ Cremation	3 ☐Removal from State	Cel	metery, cren	sition (Name of natory or other p		Date		ocation - City or		
ij	Department partment propertant:		'4 Donation 5 Other (		Hil		t Cemete		/08/04		leralsb		
Ba	permit. Departr Imports any inj		21. Signature of Funeral Service	Licensee G. Donne	,	22	. Name and Add	ress or Facility I	Frampton Federals	. Fu	neral H	Home, P.A.	
91	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to inherely cause. Enter Underlying Cause (Disease or injury)	a. Due to (or as	a conseque	my (			IN FAY C		,	Approximate Interval Between Onset and Death	
68760,	ite be executed iysicien and ne burial-transit	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):							
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	w requires that been signed t should be det	þ	Part II. Other significant condition	ions contributing to death b	out not result	ing in the ur	iderlying cause g	given in Part I.		tobacco ] Yes 2	_	the cause of death?	
Records,	The law requisate has been page 2 should	Completed							24a. Wa aut per 1 Yes	opsy formed?	prior to c death?	opsy findings available ompletion of cause of	
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medica examiner?					26. Place of	Death (Check only		, , , , , ,		
of \	S 50	မ	1 ☐ Yes 2 ☐ No	Hospital: 1 🗌 Inpatie		Outpatien	3 DOA		g Home 5 ☐ Re	sidence	6 ☐ Other (Spec	ify)	
	ding Ph h. After th funeral	<u></u>	27. Manner Peath 1 Pendi 5 ☐ Pendi		y Year) 2	8b. Time of Injury	28c. Inju		28d. Describe	how inju	ry occurred		
Division		Certification;	2 Accident Invest 3 Suicide 6 Could 4 Homicide determ	nined 286. Place of Inj	ury - At hom c. <i>(Specify)</i>	e, farm, stre		⊒Yes 2⊡No	28f. Location City or To	(Street ai own, State	nd Number or Rui a)	ral Route Number,	
_	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filed in by the	Medical Co	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the best Examiner: On the basis o and manner st	t examinatio	edge, death on and/or inv	occurred at the estigation, in my	time, date and pl opinion, death o	ace, and due to the ccurred at the time	e cause(s	) and manner as d place, and due	stated. to the cause(s)	
	To the within 2 To the complet	₩ W	29b. Signature and title of certific	er S	-7 0		29c. Licer	nse number		29d. Da	ite signed (Month	, Day, Year)	
•			2 melon	1/1/	An .	nso	D	3146	6	4	14/00	,	
			30. Name and address of person			-	Print)	10	.~ ,	-//	1/07		
			Ludwig J/		IIL	503	Cynuso	d DRIVE	Easte	9, 1	ND 216	0/	
	Sta Registr		31. Date filed (Morith, Day, Year,	32. Registr 5 2004	ar's Signatu	re And	Coast 1						

			1 - For State Registrar	State of Marylan		artment of H			ene . No. 200	4_12950
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last Lewis Gayle Adam 4e. Fecility Name (If not institution, give	5		4b. City, Town, or	Location of Death	2. Date of Death Month March	Dey Year 29 2004 4c. County of Dea	
	Funeral Director		227-42-7310	7. Age (In yrs. I		Rising If Under 1 Year Months Days	Sun If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Yo November	Cecil 9. Bir 29, 1933	thplece (State or Foreign ountry)  VA
Maryland 21215-0036	td be filed within 72 hours after death with the Maryland ental hygiene. ked other than "neturel", or items 23a or 28a-f ehow ic event, the Medical Exeminer must be notified at	o Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MD  Cecil  10e. Street and Number  143 Simmers Road  11. Marital Status  1 Never Married 2 (XMarried 3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest gra  Elementary/Secondary (0-12)  10  17. Father's Name (First, Middle, Last)  Colonel E. Adama	12. Was Decedent Ever in U.: Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1956- ucation de completed) College (1-4or 5+)	-58 16a. Decec (Give life. I		Specify: ation fluring most of work  AATOT  18. Mother's Name	pecify Yes or No- Dican, etc.)	•	erican Indian, te, etc. LLC /Industry
Baltimore, Mary	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marks eny injury or other traumatto <u>once.</u>		19a. Informant's Name/Relationship (1)  Betty J. Adams /  20a. Method of Disposition  1 X Burial 2 Cremation 3 Companies of Companies 5 Companies of	Type, Print)  Wife.  Removal from State  20b. Pl.	14. ace of Dispo metery, cren Le Feli ch Cer	3 Simmers sition (Name of natory or other place Lowship Bo no teny and any Addres	Road, Reaptist 0.	CS (NG Strn.) Date 200	ity or Town, State, MD 2191 Location - City or Rising St Funeral	Town, State un, Maryland Home, P.A.
8760,	physician and physician price be executed with the purish transit is the burial-transit	dical Examiner	23a. Pertil. Enter the disease or company shock, or heart failure. List only of the company shock, or heart failure. List only of the company shock of the c	b. Due to (or as a consequent.)  Due to (or as a consequent.)	ents of):	0 1	g, such as cardiac			Approximate Interval Between Onset and Death
P.O. Box 6	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
Records, P.	The law requires that the de ate has been signed by the a page 2 should be detached f	by	Part II. Other significant conditions or	ontributing to death but not resul	lting in the un	iderlying cause give	n in Part I.	1 🗆 Yes	2 1 № 3 Pr	the cause of death?
		Be Completed	25. Was case referred to medical examiner?			-10-10-	26. Place of Deat	24a. Was an autopsy performed 1 Yes 2 (Check only one)	? prior to death?	topsy findings available completion of cause of
Division of Vital	Attending Physician: r death. sctor: After this certific: by the funeral director, p	Certification: To	1 Yes 2 Ho  27. Mann Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	R/Outpatient 28b. Time of Injury	28c. Injury Work' M 1 \( \supers	at ?	me Residence 28d. Describe how in	njury occurred	
DİV	p at C		4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)  slcien: To the best of my know	dedge, death	occurred at the time	a date and place	28f. Location (Street City or Town, St	ate)	
•	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier  William  (Check only 2 □ Medical Exemotion)  29b. Signature and title of certifier	iner: On the basis of examination and manner stated.	on and/or inv	29c. License	inion, death occurr	ed at the time, date a	Date signed (Month	to the cause(s)
	₹↓↓ Sta Registr		30. Name and address of person who described (Month, Day, Year)	32. Registrar's Si natu	h	Print)  D	8 Lan	N Stree	Ta Ab	erdeen
	riegisti	at	MAR 3 1 20	104	Ser All	RIVER S				

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legib	ole
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	1 - For State Registrar	State of Marylan		artment of F rtificate of			iene g. No. 20(	14 1295
Physician /Medical Examiner	4a. Facility Name (If not institution, give	s		4b. City, Town, o	r Location of De	2. Date of Death Month March 2	Day Yee	2:17 A M
Funeral	Gilcrist Hospice  5. Social Security Number  5.78 36 0147	× 7. Age (In yrs.	last birthday) Yrs.	Towson If Under 1 Year Months Days	If Under 24 H	n. (Month, Day,	Baltimo:	re irthplace (State or Foreign Country)
Director	Usual Residence of Decedent  10a. State 10b. County		y, Town or Lo	cation		Feb 6,	1910   I1:	10d. Inside City Limits
vith the Mar t or 28a-f st be codiffed Director	Maryland Howard  10e. Street and Number		Co1u	mbia 10f. Zip Code		10	g. Citizen of What (	1   Yes 2   No
ltems 23s	5400 Vantage Po: 11. Marital Status 1 Never Married 2 Married	int Road #1206  12. Was Decedent Ever in U. Armed Forces?  1 Yes 2 No If Yes, Give XX Year or Dates:	S. 13. V	21044 Vas Decedent of H f Yes, specify Cuba	·	(Specify Yes or No- into Rican, etc.)	United S 14. Race - Arr Bleck, Wh Specify:	nerican Indian, iite, etc.
d 2 should be filed within 72 hours at this and Mental Hygiens of 16 marked other than "natural; or traumatic event, the Medical Evan To Be Completed by F	15. Decedent's Edi (Specify only highest grace Elementary/Secondary (0-12)	cation	(Give	AA lent's Usual Occup kind of work done of OO NOT use retired	during most of w	orking	6b. Kind of Busines	•
be filed ntat Hygind other event, Be Co	17. Father's Name (First, Middle, Last)  Edwin M. Wake	eman	Accou		Grac	e 0. McKer	aiden Sumame) Nzie	Country Clu
	19a. Informant's Name/Relationship (T)  John N. Lyon (Per  20a. Method of Disposition	Rep)	1000		Road, B	Rural Route Number, rookeville		33
Dermit. Pages 1 ar Department of Hea Mportant: If Item sny injury or othe 2006.	1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Lights	Lee	Crema 22	tory Mar Name and Addres	ch 31.	2004 ( ee Funeral	linton, M Home, Inc	laryland 6633 Old
cate be executed Whedical Examiner the buriat-transit dical Examiner		Due to (or as a consequence).	Do not ente	or the mode of dyin	g, such as cardia	ac or respiratory arres	it,	Pand 20735 Approximate Interval Between Onset and Death
nat the death certificate d by the attending physietached for use as the Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 □i	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	Part II. Other significant conditions con	stributing to death but not resu	iting in the un	derlying cause give	n in Part I.			o the cause of death?
The lay ate has page 2	25. Was case referred to medical					24a. Was an autopsy performe 1 🗆 Yes 2	prior to death?	utopsy findings available completion of cause of 2 No
Physicial this certail direct	examiner?	(Month, Day Year)	28b. Time of Injury		r: 4 Nursing I	ath (Check only one) Home 5 Residence 28d. Describe how		raity) Hospice
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification:	4 Homicide determined  29a. Certifier Certifying Phys	28e. Place of Injury - At hor building, etc. (Specify, lician: To the best of my know	vledge, death	occurred at the time	e, date and place	City or Town,	of old managers	
To the Hospital within 24 hours a To the Funeral I completely filled Medical Ce	29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who and address of person who are also as a second sec	ier: On the basis of examinati	on and/or inve	stigation, in my op	inion, death occi	urred at the time, date	and place, and due	to the cause(s)
State Registrar	31. Date filed (Month, Day, Year)	32. F gistrar's Signatu	20a) (1ype, P	W-Char	les ST	. Balt	o. and 2	1204

		•	State	State of Maryland		rtment of H			ene 200	4 12952
	7		1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia	ın	Agnes	Marie		Burke		Month March 3	Day Yeer 1. 2004	1:09 P M
	/Medic Examin	200	4a. Fecility Name (If not institution, give stre	eet and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
	LAdillil	-	12407 Kembridge			Boy	vie		Prince (	George's
-5	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Bir	thplace (State or Foreign country)
	Director		377 10 1702	83	Yrs.			August	16,1920 Ma	ryland
	pu 🔉	-	Usual Residence of Decedent  10a, State 10b, County	10c. City,	Town or Loc	cation				10d. Inside City Limits
	sho sho	5	Maryland Prince Geo	orge's		Bowie				1 ☐ Yes 2 📉 No
	28a-1	ect	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	with with the second		12407 Kembridge	Drive		20715		1	J.S.A.	
	s filed within 72 hours after death with the Maryland typiene. Alypiene. of tems 23a or 28a-f show other than "natural", or items 23a or 28a-f show ent, the Madical Examiner must be notified at	Funeral Director	11. Marital Status	. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, Whi	
0	or Iter	F	1 Never Married 2 Married	Armed Forces?  1 ☐ Yes 2 ☐ No	i	Yes 2 No	Specify:	Triodin, otor,	1	
2	raff, c	1 by	3 Widowed 4 Divorced	If Yes, Give 7. Year or Dates:		X			Specify: Whi	
ה ה	72 h	Completed	15. Decedent's Educa (Specify only highest grade of		(Give )	lent's Usual Occupa kind of work done of OO NOT use retired	furina most of work		6b. Kind of Business	Industry
V	vithin han	d m	Elementary/Secondary (0-12)	College (1-4or 5+)	111 O. L	Homemal			Home	
7	iled y Hygie ther t		17. Father's Name (First, Middle, Last)			TTOMCERCS		e (First, Middle, M		
	ould be ! Mental I arked o	9 Be	Richard Colton Wo	odburn			Agne	s Lorrain	ne Harden	
2	2 should be and Mental is marked is raumatic ev	ို	19a. Informant's Name/Relationship (Type	, Print)					City or Town, State,	
Ž	D = C =		E. Marie Burke, (Da	aughter)	1172	28 Stones			a, Maryla	
ē,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20028.	Ī	20a. Method of Disposition	cen	ce of Dispos	sition (Name of natory or other plac	e) April	Date 7. 200 4	Oc. Location - City or	Town, State
Баппто	Page ent o nt: If ry or		1 🖾 Šuriai 2 □ Cremation 3 □ Rer 1 □ Donation 5 □ Other (Specify)	noval from State		Veterans	Cemetery		Chelteham,	, Maryland
	mit.	Ì	21. Signature of Funeral Service Licensee						Home, Inc	
מ	Depa Impo any in		Kall My t	ap MOS 119						Land 20735
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Cardiac	0	rrhyt	hmia			011001 0110 01111
	/Medical		resulting in death)	Due to (or as a conseque	ence of):	11111				Lubak
	Examiner		Sequentially list conditions, b.	Due to (or as a conseque	014					1 week
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ince or):	Train 1	111			Imanth
	be executed ician and burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as a conseque	erice of):	DEWIL	TY			111101.111
/60,	ate be executed hysician and the burial-transit	cal E					/			
280	death certificate e attending phys d for use as the		d.							
ŏ	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of pregnance					23d. Date of de	
ñ	atter d for u	clar	in the past 12 months?	1 Live birth 2 Fetal d 4 Pregnant at time of dea		]Ectopic pregnancy ] Other (specify)			Month	Day Year
o.		nysi	9 Unknown	9□ Unknown						
ت. ح	The law requires that the site has been signed by the bage 2 should be detache.	by P	Part II. Other significant conditions contri	ibuting to death but not result	ting in the ur	nderlying cause give	en in Part I.			o the cause of death?
2	quire en sig uld b		(Stepporosi	5				1 XYes	2 No 3 P	robably 4 Unknown
Kecords,	aw re	Completed	COPD - I	Empluse	ma			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
	The late has	E	Atrial Fil	rillation				perform	ed? death?	s 2 No
I		BeC	25. Was case eferred to medical	Trica Horr			26. Place of Deal	h Check onl one	1	
of Vital	Physician: The lavithis certificate has al director, page 2	To	examiner? 1 ☐ Yes 2 No		R/Outpatien		4   Nursing H	400.00		ecify)
	ng Ph Iter th		27. Manner of Death  1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe how	v injury occurred	
<u> </u>	endii eath. or: Al	catle	2 Accident investigation				Yes 2 □No	206 Leasting /Cts	eet and Number or R	lural Route Number
Division	r Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, tarm, str	eet, factory, office		City or Town,		urai moute raumber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific; completely filled in by the funeral director.		One Continue To Annual Continue Continu	cien: To the best of my know	ledge death	Occurred at the time	ne date and place	and due to the ca	use(s) and manner a	s stated.
	Hos 24 ho Fune tely fi	Medical	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine one)	er: On the basis of examination and manner stated.	on and/or in	vestigation, in my o	pinion, death occur	red at the time, da	te and place, and du	e to the cause(s)
	o the ithin o the omple	Mec	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
)	ة € ₹		) MASTX	$\sim$		7	5116	9	3/3	1104
			30. Name and address of person who com	pleted cause of death (Item:	23a) (Type,	Print)		1	7	
N	1P.5		Konni Brings	nan .mb	4	201 Mita	chelluil	le Red,	#102	BOWIE, MD
35	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ILE TO	land.				20716
	Regist	ror	APK U [ 2	UUT DECK	100	A PERSONAL PROPERTY.				

		1 - For State Registrar	State of Maryla	nd / Dep	artment of F	lealth and	Mental Hy	giene Reg. No. (	2004		
Physic /Med Exam	ical	Devedent's Name (First, Middle, Last     DAVID RAYMOND BU     4a. Fecility Name (If not institution, give     MALCOLM GROW MEDI	RKE street and number)		4b. City, Town, or		2. Date of De Month APRIL	10,	2004 inty of Deeth	3. Time of Death 11:50 A M	
Funera Director		5. Social Security Number 6. Se 118–34–0302		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi				place (State or Foreign	
Maryland a-f ehow	ctor	Usuel Residence of Decedent  10a. State 10b. County  Maryland Charles		City, Town or Lo Valdorf	ocation				10d. Inside City Limits 1 XYes 2 □ No		
with the 3a or 28 d be not	i Director	10e. Street and Number 312 Tompkins Lan	e		10f. Zip Code 20602			10g. Citizen USA	of What Coul	ntry?	
within 72 hours after deeth with the Maryland jene. I then "natural", or Ileme 23s or 28s-f ehow I'le Medleal Ezant. at must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 3€ No	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)		Race - Americ Black, White, ecify: Wh		
within ene. then	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired d Forces	ation during most of w	rorking		f Business/In nal Se	dustry curity	
should be filed and Mental Hygi marked other	To Be C	17. Father's Name (First, Middle, Last)  Raymond Burke				Marga	ame (First, Middle	ey Bur	ke		
and 2 should ealth and Mer n 27 le marks	ì	19a. Informant's Name/Relationship (T) Pamela J. Burke (			ng Address (Street Tompkins					Code)	
of Ho		20a. Method of Disposition  1  Burial 2 XCremation 3 1  4 Donation 5 Other (Specify,	M-		osition (Name of matory or other place Vets Cen		Date 6-04		on - City or To enham,		
permit. Peg Department Important: I any injury o		21. Signature Funeral Service Incens	M00173		2. Name and Addre	E	berwein La. Whit				
Physiciar /Medica		23a. Part Enter the disease, or comp index, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the de one cause on each line.  HEPATIC ENC a.  Due to (or as a conse	EPHALOE		ng, such as card	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death 20 HOURS	
te be executed SXE spician and Executed SXE SXE SXE SXE SXE SXE SXE SXE SXE SXE	Ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HEPATIC FAI  Due to (or as a conse  c. HEPATIC CIR  Due to (or as a conse  d.	LURE equence of): RHOSIS							
The law requires that the death certificate to has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[	□Ectopic pregnancy	,		23d.	Date of delive	ery Day Year	
quires that i	Ď	Part II. Other significent conditions co	entributing to death but not re	esulting in the u	inderlying cause giv	en in Part I.		obacco use c Yes 2 □ No		he cause of death?	
	Completed						24a. Was auto perfo 1 Yes	psy ormed?	b. Were auto prior to co death? 1 \( \text{Yes}	psy findings available impletion of cause of	
Physicien: rthis certific ral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 XInpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	0.0	Home 5 Resi		Other (Specif	(v)	
	Certification: T	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe	how injury oc	curred		
		4 Homicide determined	building, etc. (Spec	cify)			City or To	wn, State)		al Route Number,	
To the Hospital of within 24 hours af To the Funerel D completely filled in	Medical		sician: To the best of my k iner: On the basis of exami and manner stated.								
To the within To the comp	Z	29b. Signature and title of certifier			29c. Licens				ned (Month,	Day, Year)	
0111		30. Name and address of person who o	completed cause of death (It	em 23a) (Type.	Print) 89 MD	-	WEST PER		RD		
006	tate	JULIANNE FLYNN, M. 31. Date filed (Month, Day, Year)	32. Registrar's Sig			WS AIR 1	FORCE BAS	E, MD	20762		
Regis		APR 13 2	004 Some		bertes						

Design and Descendent   Desce	1295
Director   Director	1842 ^
To State Mary Design of the Control	rges ace (State or Foreig try) ngton,D C
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   Nancy Scott Brown Middleton   N	0d. Inside City Limits 1 X Yes 2 No
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   Nancy Scott Brown Middleton   N	try?
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   Nancy Scott Brown Middleton   N	etc.
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   Nancy Scott Brown Middleton   N	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2)	
Burial 2 Other (Specify)  21. Signature of Funeral Service Licensee  4 (Specific Service)  4 (Specific Service	and
Physician (Medical Examiner)  Physician (Medical Examiner)  Sequentially list conditions, fany, leading to immediate cause (Final disease or condition resulting in death) Last  Due to (or as a consequence of):	aryland
FFEMALE:	Interval Between Onset and Death MWV [11]
autopsy performed?    Part   P	ry Day Year
autopsy performed?    Part   P	e cause of death? ably 4 Unknow
§ ≝ ☐ ☐ 1 Yes 25t No ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ 4 ☐ Nursing Home 5 to Residence 6 ☐ Other (Speci	osy findings available appletion of cause of 2 No
27. Manner of Death  1 Natural  1 Natural  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  M  28c. Injury at Work?  1 Yes 2 No  28d. Describe how injury occurred	·)
building, etc. (Specify)  City or Town, State)  City or Town, State)	Route Number,
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a continuous control of the cause (s) and manner as a control o	ated. the cause(s)
290. Signature and title of certifier  D43346  290. Date signed within the property of the pro	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  RITA GOPTA MD 8926 WOODYARD ROAD #201, CLINTON MD  State  31. Date liled (Month, Day, Year)  APR 13 2004	20735

			For State	State of Ma		ertificate of		nd Mental H		000	100-
			Registrar     Decedent's Name (First, Middle, I	ast)		Tillicate of	Dealii	2. Date of I	Reg. N	10. ZUU	1 295
	Physic		Thomas Ea	rl Brad	Cr			Month	D	ay Year	3. Time of Death
	/Medi Exami		4a. Fecility Name (If not institution, g		y, Sr.	4b. City, Town, o	or Location of	Apri Apri		2004 c. County of Deat	7:15 p <sup>M</sup>
1	Exami		Calvert County		er	Prince					
	Funeral	Г		Sex 7. Age	(In yrs. last birthday	ff Under 1 Year	If Under 24	Hrs. 8. Date of E	Birth	Calvert 9. Birt	hplace (State or Foreign
	Director		213-36-0110	1 <b>∑</b> M 2□F	81 Yrs.	Months Days	Hours	Min. (Month, I	Day, Yeal	7)   60	ryland
	pu ,		Usual Residence of Decedent					1000.	13/1.	722 PU	Lytana
	show	-	10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	the Ma	octo	Maryland Calver		Owings						1 ☐ Yes 2 No
	with ti	Dir	10e. Street and Number	D - 3		10f. Zip Code	_		10g. C	itizen of What Co	untry?
	s 23a	rai	2540 Chaneyville			2073				U.S.A.	
	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Items 23a or 28e-1 show other traumatic event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of H If Yes, specify Cubi	lispanic Origir an, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)	No-	<ol> <li>Race - American Black, White</li> </ol>	rican Indian, a, etc.
98	urs a	þ	3 ☑ Widowed 4 □ Divorced	If Yes, Give X Year or Dates:		1 ☐ Yes 21 No	Specify:			Specify: wh:	ite
215-0036	2 ho	Completed	15. Decedent's 1	ducation	16a. Dece	dent's Usual Occup	ation		16b. h	Kind of Business/I	ndustry
218	hin 7	pie	(Specify only highest g Elementary/Secondary (0-12)	rade completed)  Colfege (1-4or 5+)	(Give	kind of work done DO NOT use retired	durina most o	f working	100.1	and of businessy	noustry
2	filed withi Hygiene. other ther	S	6			mer			fa	armina	
	al Hygir d other	Be (	17. Father's Name (First, Middle, Las	t)			18. Mother's	Name (First, Middl			
Maryland	should be filed within the Mental Hygiene.  I marked other then umatic event, IL & M.	10	Thomas Joseph	n Brady			Addi	e R.	Grie	erson	
a	2 sho and is mu		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ng Address (Street	and Number o	r Rural Route Num	ber, City	or Town, State, Zi	ip Code)
	of Health of Health item 27 if		Thomas E. Brady,	Jr., son	2370	Harley Ru	ın, Owi	ngs, MD 2	20736	5	
ore	of H of H if iter		20a. Method of Disposition 1   Burial 2 □ Cremation 3 i	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place Le Cemete	e)	Date	20c. L	ocation - City or T	own, State
Ē	Pages ment of h ant: If ite		`4 Donation 5 Dother (Spec		Smithvil	le Cemete	ry 4-	5-2004	Dun	kirk, MD	)
Baltimore,	permit. Pages Department of Important: If it any injury or ones.		21. Signature of Funeral Service Uce	nse selace		2. Name and Address Rausch Fur		lome, P.A.	, Ow	vings, MI	20736
			23a. Part1. Enter the disease, or con shock, or hear failure. List only	applications that caused the							Approximate
	Physician		Immediate Cause (Final disease or condition		THE						Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a c							
Н	Examiner		Sequentially list conditions, bPneumousa								
	ed sit	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a c							
	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	·	Tever						
30,	sian surial		resulting in death) East	Due to (or as a d	onsequence of):						
58760,	ate b	dicai		d							
•			IF FEMALE:								
Вох	taw requires that the death certifical as been signed by the attending p 2 should be detached for use as:	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 [	Fetal death 3	Ectopic pregnancy				23d. Date of delive	•
	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne of death 5	Other (specify)				Month	Day Year
P.0	that the ed by detac		Part II. Other significant conditions	contributing to death but r	not resulting in the u	adosh i a a a	a ia Dant	00 - Did			
ds,	signe d be	l by		John Dating to addit but i	or resulting at the d	idenying cause give	n in Part I.				he cause of death?
Ŏ	w requir been si should	etec						- "	Yes 21	□No 3□Prob	oably 4 Unknown
Vital Records,	The fav	Completed						– 24a. Was	psy	prior to co	psy findings available mpletion of cause of
a								1 ☐ Yes	ormed? 2 ☑ No	death?	2 No
<b>=</b>	yaician; 'yaician; 's certifica director, p	Be	25. Was case referred to medical examiner?	Hospital:		0#-		Death (Check only o			
Ö	Phyaician: this certificant	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient	2 ER/Outpatien		4 ursin	g Home 5 ☐ Resi			y)
	ing After	ion	1-☑Natural 5 ☐ Pending	(Month, Day Y	ear) 28b. Time of Injury	28c. Injury Work		28d. Describe	how injur	y occurred	
<u> </u>	a ta :: e	ical	2 Accident investigatio 3 Suicide 6 Could not b	Α -	At home - 6		es 2 □No		_		
Division	II or Attend after death Director: / d in by the f	Certification;	4 Homicide determined	28e. Pface of Injury building, etc. (	Specify)	eet, factory, office		28t. Location ( City or To:	Street and wn, State,	d Number or Rura )	I Route Number.
_	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th		29a. Certifier Certifying Pt	vsicien: To the boot of	v knowledge do-th	occurred at the city	n data a di i	M.			
	e Ho: 24 h e Fur etely	edicai	(Check only one)	ysicien: To the best of miner: On the basis of ex and manner stated	amination and/or in	estigation, in my op	e, date and pla inion, death o	ace, and due to the courred at the time,	cause(s) date and	and manner as st place, and due to	ated. the cause(s)
	vithin o the	Me	29b. Signature and title of certifier	side side		29c. License				e signed (Month,	
	- > - 0	İ	D. Shah	115		7	5029	1		- 2-04	
			30. Name and address of person who	Completed cause of death	(ftem 23a) /Tune		3041			7 07	
	10		Dhiven Shah		$0.5 \beta RD$	Poli	14	Frednia	/	up 2	0678
	Sta	te	31. Date fifed (Month, Day, Year)	32. Registrar's	Signature					- / 1	0 / 0
	Registra	_	APR 0 5 2004	Blown &	back	>					
	IH 17 Rev 1/20	.04	<del></del>	K	-						

		For State Registrar	State of Maryla	nd / Depa	artmer		ealth and	d Mental H	Reg. No. 6	2004		
Physic	ian	1. Decedent's Name (First, Middle, Last George P.	Bonbrest					2. Date of D Month <b>March</b>	Day	2004	3. Time of Death 4:01P	
/Medi Exami		4e. Facility Name (If not institution, give			4b. City	, Town, or	Location of De			county of Death		
LXami	iei	Shady Grove Adve	ntist Hospita	1	Ro	ckvi	11e		M	ontgom		
Funeral Director		5. Social Security Number 6. Se 578–56–6084  Usual Residence of Decedent	x 7. Age (In yrs	. last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 H Hours M	B. Date of B. (Month, Dec. 9	ay, Year)		nplece (State or Foreign untry) nington D.C.	
ryland how		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limi 1 ☐ Yes 21 ☐ N		
death with the Maryland ms 23s or 28s-f show	Director	Maryland Montgome  10e. Street and Number	ry Gen	mantow		p Code			10g. Citize	en of What Co		
ath w		11105 Hoffman Dr	ive 12. Was Decedent Ever in U	16 12	Was Dags	208		/Specify Voc or h		S.A. Race - Amer	rican Indian	
	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	1	If Yes, spe		Specify:	(Specify Yes or Nierto Rican, etc.)		Black, White	e, etc.	
within 72 ho ene. then "nature the wad call	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le <i>completed)</i> College (1-4or 5+)	16a. Dece (Give life.	kind of w	ial Occupa ork done d use retired,	furing most of v	working		of Business/l	ndustry er – Wine	
Baltimore, Maryland ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or any injury or other treumatic event, the Medical Exam proces.	Be	12th 17. Father's Name (First, Middle, Last) Louis Bonbrest		S	tore	Oper	18. Mother's N		dle, Maiden Sumame) Royston			
2 should and Men is marke eumatic	10	19a. Informant's Name/Relationship (T	/pe, Print)	19b. Maili	ng Addres	s (Street a		Rural Route Num			ip Code)	
Ind 2 alth a alth a street		Vicky Lynn Bonbre	st - Wife	111	05 Ho	offma	n Drive	e, German	town,	Maryla	and 20876	
DEMILITIONE, I permit. Pages 1 and Department of Heali Important: If Item 2 any injury or other once.		20a. Mathod of Disposition  1 Burial 2 Cremation 3 1  4 Disposition 5 Other (Specify,	Removal from State	Place of Dispo cemetery, crei	matory or	other place	1	Date ch 24, 2		ation - City or 1	rown, Stete ck. Maryland	
permit. Par permit. Par Departmen important: any injury once.		21. Sign ture of Finerat Service Licens	96	22	2. Name a	nd Addres	s of Facility	1 7	-	1	34:	
Physician /Medical Examiner		23a. Part 1. Scienthe disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	1 15	che	M 1 G	g, such as card	the infa	arrest, v C tro	on	Approximate Interval Between Onset and Death	
od fou, reate be executed physicien and s the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.)						-			
death certif	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	death 3 Ectopic pregnancy					d. Date of deli	very Day Year	
rds, F.C. quires thet the on signed by the		Part II. Other significant conditions co			inderlying	cause give	on in Part I.			_	the cause of death?	
	Completed								s an opsy ormed? 2 No	24b. Were aut prior to c death? 1 \( \subseteq Yes	topsy findings available ompletion of cause of	
cian: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	ar	Death (Check only				
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ition: To	1 Yes 2 No  27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury Work	at	g Home 5 Res			ify)	
Hospitel or Attending P     24 hours after death.     Funerel Director: After telety filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec		reet, facto	ry, office			(Street and in which state)	Number or Ru	ral Route Number,	
he Hospit n 24 hours he Funere	edicai (		rsician: To the best of my kr iner: On the basis of examin and manner stated.						, date and p	lace, and due	to the cause(s)	
To the h within 2 To the I	W	29b. Signature and title of certifier	cellin		29	c. License	4. 25	18	29d. Date	signed (Month	20, 2004 20, 2004 20852	
X		30. Name and address of person who co	ompleted cause of death (Ite	ет 23a) (Тура,	Print)	-E /	Diteo,	# 401 S	Octe	veur-	20852	
St Regis	ate trar	31. Date filed (Month, Day, Year) MAR 2 2	32. Registrar's Sign		hoe	X)						

		_	1 - For State Registrar	State of M	aryland		artment of H		nd M		iene <sub>eg. No</sub> 2 (	004	12957
	Dharalais		Decedent's Name (First, Middle, L.)	ast)						2. Date of Deat Month		Year	3. Time of Death
	Physicia /Medic	al .	Robert Lee Burn					15	( 5	March	12,	2004 unty of Death	12:30 A M
	Examin	er	4a. Facility Name (If not institution, gradual facility Name (If not institution, gradual facility Name (If not institution, gradual facility Name (If not institution, gradual facility Name (If not institution, gradual facility Name (If not institution, gradual facility Name (If not institution, gradual facility Name (If not institution, gradual facility Name (If not institution, gradual facility Name (If not institution, gradual facility Name (If not institution), gradual facility Name (If not instit		)		4b. City, Town, or	Oak1			40. 000	Garı	
	Funeral			Sex 7. A	ge (In yrs. Ia	st birthday)	If Under 1 Year	If Under 2		8. Date of Birth (Month, Day,	Year)		place (State or Foreign untry)
	Director		215-42-9343	1⊠M 2□F	61	Yrs.	Months Days	Hours	]	Feb. 24	, 1943	3 M	aryland
	and w	-	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or La	cation						10d. Inside City Limits
	Mary! -f sho	tor	MD Gai	rett			0akla	nd					1 ☐ Yes 2 X No
	th the or 28e e notifi	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen	of What Cou	untry?
	ath will		628 Clifton Dr						550	-:	14	USA Race Amer	ican Indian
36	72 hours after death with the Maryland 'natural', or Items 23s or 28s-f show dioal Exactions roual be notified at	by Funeral	Narital Status     Never Married 2 ☑ Married     Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1  Yes 2 4 If Yes, Give Year or Dates:	? [No		Was Decedent of Hi f Yes, sp <i>ec</i> ify Cuba 1 □ Yes 2⊠ No		jin? (Spe , Puerto F	city Yes of No- Rican, etc.)		Bleck, White	
9	72 hou		15. Decedent's	Education	1	16a. Deced	dent's Usual Occupa	ation Jurina most	of working	na	16b. Kind o	of Business/I	ndustry
215	c • 🖼	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done of DO NOT use retired						
121			10th 17. Father's Name (First, Middle, Las	(t)		Au	to Mechar		r's Name	(First, Middle, I		o Repa	air
and	be od o	To Be		Liver	Buı	rns		Myrt			lia		llsworth
Maryland 21215-0036	de E	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street a	nd Numbe	r or Rura	Route Number	, City or To	wn, State, Z	ip Code)
	t and 2 Health a tem 27 Is other tra		Betty E. Burns/	wife	act. Di		Clifton I	rive,	- PRINCE			.550 on - City or 1	Favor Chata
Baltimore,	500		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3		1 00	ace of Dispo	sition (Name of natory or other plac						
Him	permit. Pages Department of Important: If i any injury or once.	1	'4 □Donation 5 □ Other (Special Signature of Funer National Service Line		_   Au		emetery Name and Addres		3/14	:/04 Stewart		ra. W	
Ba	Department of the services once		1 Devella 1	Down			2 S. Seco		, D				iie
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition			. Do not ent	er the mode of dyin	g, such as o	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	a. Prieumo Due to (or a		ence of):							l week
Н	Examiner	پ	Sequentially list conditions,	b. Metast	atic	Lung (	Carcinoma					-	6 weeks
_	rted	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury		o a concoqu								
ó	ate be executed hysician and the burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (or a	s a consequ	ence of):							
3760,	ate be hysicia the bu	lical		d					-				
Box 68	ath certific ittending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1□Live birth 4□Pregnant	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)				23d.	Date of deliment	very Day Year
o.	that the de led by the a detached f	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown									
rds, P.	sign sign	ρ	Part II. Other significant conditions	contributing to death	but not resu	Ilting in the u	nderlying cause give	en in Part I.			bacco use d es 2□N		the cause of death?
l Records,	The law ate has b page 2 s	Completed								24a. Was a autops perform	sy	prior to c death?	topsy findings available completion of cause of
Vital	Physician: The I this certificate ha	Be	25. Was case referred to medical examiner?	Hospital:			oth Oth			(Check only or			
ō	ਜ਼ੂ ਦੇ ਯੂ	lon; To	1 Yes 2 No  27. Manner of Death  1 Natural  2 Accident investigat	28a. Date of In		ER/Outpatier 28b. Time o Injury	1 28c. Injun	4 🗆 Nu	2	ne 5 PReside 28d. Describe he		-	ify)
Division	or Atten after deat Director: in by the	Certification:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	be 28e. Place of I	njury - At ho etc. <i>(Specif</i> y	me, farm, st	reet, factory, office		2	28f. Location (S. City or Town	treet and N n, State)	umber or Ru	ral Route Number,
_	e Hospital 24 hours a e Funeral letely filled	Medical C	29a. Certifier 1	Physician: To the bes aminer: On the besis and manner:	of examinat	wledge, deat ion and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, a	and due to the c	ause(s) and ate and pla	d manner as ice, and due	stated. to the cause(s)
_	within 2 To the Comple	Me	29b. Signature and title of certifier	111			29c. Licens	e number		2	9d. Date si	gned (Month	n, Day, Year)
			) de	San Parker and San Pa	yell address of the control of the c	-	D239	79		(	03/15	/2004	
			30. Name and address of person wh	o compléted cause of						0.1 = - 0			
	21	ate	Robert A. Gorals 31. Date filed (Month, Day, Year) MAR	32. Regis	trar's Signa	ture	th St Oa	kland	, MD	21550			

\		For State Registrer	State of Marylar		artment of H		nd Menta		ene 2 0	0 L	12958
Physici	an	1. Decedent's Name (First, Middle, Last)  Mayu E Bro	wn				2. Date Mor		Dey (0 20	Year	3. Time of Death
/Medio Examin		4a. Facility Name (II not institution, give: Mercy Medical			4b. City, Town, or Battime				4c. County of Battin		City
Funeral Director		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date (Mo) May	of Birth orth, Day, Y 29 1	.933	9. Birthpl Count MD	ece (State or Foreign try)
Aaryland I show	or	Usuel Residence of Decedent  10a. State 10b. County  MD		y, Town or Lo						10	0d. Inside City Limits
with the hand or 28a-	Direct	10e. Street and Number 416 N Chapelgate I		a I CIIIOI	10f. Zip Code 21229			10g	. Citizen of W	hat Coun	try?
I ey, INICAL Y ICALING A 12-10-000  8.1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, II.a Medical Examinar meatic event, II.a Medical Examinar meatics routified at	by Funeral Director		12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Orig an, Mexican, Specify:	in? (Specify Ye., Puerto Rican, e	s or No-		- America , White, e	etc.
within 72 hou sne.	Completed I	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most	of working		Library		lustry
at yidilid Kilk should be filed with and Mental Hygiene. I marked other the umatic event, Itel	To Be Co	17. Father's Name (First, Middle, Last)  Lawrence Bombero	ger			Hul	rs Name (First, da Bisho	op			
and 2 sho alth and I m 27 is me		19a. Informant's Name/Relationship (Ty Hulda Kay Brown	pe, Print)		ng Address <i>(Street)</i> Olela Avo		r or Rural Route $1$ icott (				Code)
Pages 1 and 2 nent of Health int: If Itam 27 ury or other tr		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	temoval from State	Place of Dispo cemetery, cres	osition (Name of matory or other place Cemetery	(8)	Date r 9 2004	20	c. Location - C	City or To	
Definit. Pages: Department of Pimportant: If its any injury or of once.		21. Signature of Furieral Service Licens	3 dack		Name and Address David A. 710 Churc	Burdo	ck FH			21539	
Physician /Medical		23a. Part I, Enter the disease, or compl show, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the dealer cause on each line.  BLOMUCI  Due to (or as a consec	th. Do not ent		ig, such as o					Approximate Interval Between Onset and Death
certificate be executed by a radius physicien and burial-transit and see as the burial-transit a	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec		ymphon	10					4 month
ath certific	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1.  i3c. If yes, outcome of pregn 1	aldeath 3[	□Ectopic pregnancy □ Other (specify)	′			23d. Date Mon		ry Day Year
requires that the despensioned by the a	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	inderlying cause giv	en in Part I.	23	e. Did toba 1 🗌 Yes			e cause of death? ably 4 Unknown
The law ate has t	Completed							a. Was an autopsy performe Yes 2	id? pr	ere autorior to consath?	psy findings available inpletion of cause of
OT VICAL IN Physician: The this certificate ral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ER/Outpatier	nt 3 DOA Oth		of Death (Checi		ce 6 □Othe	r (Specify	)
E 6	atlon: T	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ N		scribe how	injury occurre	d	April 10 de 10 c
2 = E	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, sti fy)	reet, factory, office	1000		ation (Stre or Town,		r or Rurai	Route Number,
Hos 24 h Fur stely	edical (		sicien: To the best of my kn ner: On the basis of examination and manner stated.								
To the within To the comple	Me	29b. Signature and title of certifier	nuella		29c. Licens		5W144-	74) N	Date signed	(Month, L	2004 2004
3		30. Name and address of person who co Stephania Well	ompleted cause of death (Ite	m 23a) (Type, 36\	Print) St. Paul	Bo	altima	ne M	anyla	nd	
St. Regist	ate	31. Date filed (Month, Day, Year)  MAR = 8 2	32. Registrar's Sign	ature	Sandy			·	7		

		1	For State Registrar	Sta	ate of M	/laryland		artment		ealth and <mark>I</mark> Death		giene Reg. No.	200	4	12950
			Decedent's Name (First, Middle	, Last)		-					2. Date of De	ath			Time of Death
Phys		-	Sara E	lizab	eth 1	Brisco	oe				April	1 1 Day	$20\overset{\text{Yeer}}{0}\overset{\text{d}}{4}$	7	:15A M
	dica nine	_	4a. Facility Name (If not institution	, give street	and numbe	or)		4b. City,	Town, or	Location of Death	1		County of Dee		
			240 North Cen	ntral	Ave	nue			dge]				rolin		
Funer	al		5. Social Security Number	6. Sex 1 ☐ M 2		Age (In yrs. la	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Bir	thplace (. ountry)	State or Foreign
Direct	or	-	219-03-0083  Usual Residence of Decedent		A-	85	115.				May 19,	1918	N	lary	land
and wc		-	10a. State 10b. County			10c. City,	Town or Lo	cation						10d. In:	side City Limits
Mary f sho		5	Maryland Carol	ine		Rid	lgely							1[	□Yes 2□No
ith the Marylar or 28a-f show		Director	10e. Street and Number					10f. Zip	Code			10g. Citiz	en of What Co	ountry?	
h with			240 North Centr	al Ave	enue			2	1660			Unit	ed Sta	tes	
r deat		runeral	11. Marital Status	12. W	as Decede med Force		S. 13. \	Was Deced f Yes, spec	ent of His	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 1	<ol> <li>Race - Ame Black, Whi</li> </ol>		tian,
or It	į į	by ru	1 Never Married 2 Marr	ied 1	☐Yes 2 [ Yes, Give ear or Date	XNo		1 ☐ Yes 2	2 No	Specify:			Specify:		
ing ZIZID-DODO I filed within 72 hours after death with the Maryland I Hygiene. Hybre than "natural", or Itame 23e or 28e-f show ent, I'm Medical Exprise man be notified at		<u>α</u>	3 ☐ Widowed 4 ☐ Divorced			s:	16a. Deced	dent's Usua	I Occupa	tion		16b. Kir	Cau	Casi.	
in 72		Completed	(Specify only highe	t grade com	pleted)	N F 1)	(Give	kind of wor DO NOT us	k done di	uring most of wor	rking				
Z Mith		E	Elementary/Secondary (0-12)  11 HS Grad	6	ollege (1-40	) (3+)	T	eache	r			F	ducati	on	
Idito A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A		De	17. Father's Name (First, Middle,	Last)						18. Mother's Nar					
should be and Menta marked	,	0	Thomas M	orris	Lynch	1					a Elizal				
VICE Shows the and the modern traumant		1	19a. Informant's Name/Relations	hip <i>(Type, P</i>	rint)		19b. Mailir	ng Address	(Street a	nd Number or Ru	iral Route Numb	er, City or	Town, State,	Zip Code	')
if e, IMBITYIBIIG ZIZID-UUDO s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene Item 27 is marked other than "natural", or Itame 23e or 28e-1 show other traumatic event, Ite Medical Exemine trust te notified at		-	Patrick M. Bris 20a. Method of Disposition	coe	_Son	20b Pla	3044	West	Rust	ic Driv	e, Salis	20c Loc	Mary cation - City or	Land.	_21804
Pages 1			1- Burial 2 ☐ Cremation	3 □Remov	al from Sta	97	ace of Dispo metery, crer				E /2004				
permit. Pages Department of H Importent: If Ite		-	4 Donation 5 Other (S 21. Signature of Funeral Service		1	Gre	enmou			ry 4/1 s of Facility	5/2004	пттт	.S.OOLO,	inat	yranc.
Depart Impo	once		V Llandon	Un P/	Moa	ب ع	M	oore	Fune	ral Home	P.A.		Money	.l and	1 21620
			23a. Part1. Enter the disease, or	complication	ns that cau	sed the death.	. Do not ent	er the mod	e of dying	ccond St , such as cardia	or respiratory a	rrest,	i, Mary	Appr	roximate
Physicia	300	-	Immediate Cause (Final	only one cal	se on each	Tilne.	- 1	100	0-		URE			Onse	et and Death
/Medic			disease or condition resulting in death)	a	Due to (or	as a consequ	ence of):	Ten	NI	TAIL				1	4/6912
Examin	er		O	b. —	1										
0 5		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Disease or injury that intend exerts.)	, "	Due to (or	as a consequ	ence of):								
and trans		Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to for	as a consequ	once of):	_							
f <b>bU,</b> tte be executed tysician and he burial-transil			rosaling in dodo, see		10) 01 800	as a consequ	erice or,								
S y s	:	dical		d											
BOX 68/ Gath certificate attending phys		Physician/Me	IF FEMALE: 23b. Was decedent pregnant			me of <u>pr</u> egnar						2	3d. Date of de	elivery	
death death e atten		Clar	in the past 12 months?	4	Pregnan	n 2 □ Fetal t at time of de		∃Ectopic pr ∃ Other <i>(sp</i>					Month	Day	Year
C the contract of the contract		hys	9 Unknown	9	Unknow	n								-	
law requires that the de as been signed by the			Part II. Other significant conditi	5 1-	1 -	h but not resu	Iting in the u	nderlying c	ause give	n in Part I.			se contribute t		
ecords, law requires t as been signed by should be		Completed by	CHKONIC C	207 11	vac Ti	VE L	UN	5 D	1>4	125	1 🗆	Yes 2	No 3 □ P	robably	4 Unknown
a a		ble									24a. Was	psy	prior to	completi	ndings available ion of cause of
The The	Par I	Ö									1 Yes	2 No	death? 1 ☐ Ye	s 2 🗆 l	No
VITAL P ilcian: Th certificete	1012	Be (	25. Was case referred to medica examiner?		-1-				0*		ath (Check only	one)			
Of VITA Physician: r this certific		ို	1 Yes 2 No	Hospi	a. Date of I		ER/Outpatier 28b. Time o			4   Nursing r	1ome 5 Res		Other (Spe	ecify)	
Jn (		ou	27. Manner of Death  1 Natural 5 Pendi	ng		Day Year)	Injury	M	8c. Injury Work	:? Yes 2 □ No	254. 5000.150	now myary	, 55541155		
DIVISION  Tor Attending after death. Director: After		Cal	3 Suicide 6 Could	not be	Be. Place of	Injury - At ho	me, larm, st						d Number or F	Rural Rou	ite Number,
DIVISION O  tel or Attending PI s after death.  el Director: After ti		Certification;	4 Homicide	iii led	building	, etc. (Specify	')				City or To	wn, State,			
DIVISION Of VITA To the Hospitel or Attending Physician: within 24 hours after death. To the Funerale Director. After this certific			29a. Certifier 1☐ Certifyi	ng Physicie	n: To the b	est of my know	wledge, deat	h occurred	at the tim	ne, date and place	e, and due to the	cause(s)	and manner a	s stated.	20,400(0)
n 24 l		Medical	(Check only 2 Medical one)	Examiner:	and manner	s of examinat	A 1	ivestigation	, in my of	pinion, death occ	urred at the time,				
To the Hospitel or A within 24 hours after To the Funerel Direct Completels with titled in the completels of the complet	3	Σ	29b. Signature and title of certific	-(1)	Lepl	Y	755	29	. License	number		29d. Date	e signed (Mon	ith, Day,	Year)
•			Kirishan	EX	ens	en /	110	٤	VI	466	<b>†</b>	TIPE	11/	4 2	:004
			30. Name and address of person	who comple	A / A	of death (Item	23a) (Type,	97	DE	NTEN	MD '	711	609		
-	C	U	31. Date filed (Month, Day, Year	SEN.	32. <b>36</b> 9	jistrar's Signat	ture e un	101		.010	- IV	416	7		
Reg	Stat gistra		800 1 9	2004	A	Suis d	B. A	parke	9						

			Please  1 - State Registrar  1. Decedent's Name (First, Middle, La	State of Ma	ryland / De		t of H	lealth and I	-	/giene Reg. No	2004	12960
	Physicia /Medic	al	Dorsey Causer  4a. Facility Name (If not institution, giv	Baynham		4b. City.	Town or	Location of Death	Apri	1 4 Da	2004 County of Death	12:55 PM
_	Examin	er	Genesis Elder C	Care - The	e Pines		Eas	ston			Talbo	
1	Funeral Director			□M 200 F	95 Yrs	Months	Days	Hours Min.	8. Date of B (Month, D April	3, 1	909 Ind	iana
1	Maryland f show	tor	10a. State 10b. County Maryland Wicomic		10c. City, Town Sa. Man	isbury	,					10d. Inside City Limits 1 Yes 2 □ No
50	with the	Il Direc	10e. Street and Number 1105 S. Schumach			10f. Zip	Code 218	04		_	tizen of What Cou	ntry?
A ser	be filed within 72 hours after death with the Maryland the Hygiene.  d other than "natural", or items 23a or 28e-f show event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	ver in U.S.	13. Was Deced If Yes, spec	۸ /	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or N Rican, etc.)	0-	14. Race - Ameri Black, White, Specify:	
7	n 72 hou	Completed	15. Decedent's E (Specify only highest gra	ide completed)	(0	ecedent's Usua live kind of wo	Il Occupa rk done d	ation during most of wor	king	16b. K	(ind of Business/In	
Baynham	uld be filed within Mental Hygiene.	Be	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last, William Penn		F)	ter/Ed			ne (First, Middle		Educatio	n
Baynham	C = 64 F	To	19a. Informant's Name/Relationship ( Leonard Baynham/	Type, Print)	1			and Number or Ru Lane, Ox	ral Route Numi		or Town, State, Zij 1654	o Code)
Dorsey	Pa ury		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special	y)	20b. Place of D cemetery,	isposition (Nan crematory or o	ne of ther plac		Date	20c. L	ocation - City or T	
OO	permit. Pag Dep. rtment Imp. rtent: any njury o		21. Sign we of Funeral Service Ice	ran- The	mwe	Mid Sh Plo B	ore ox 1	Crematio	n Cente bridge,	r, 2	272 Huds 21613	on Rd.,
	Physician /Medical Examiner punial-transit prinal-transit	Examiner	23a. Rant: Enter the disease, of comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of)	we 4	1 av	A Ja	Mus-	d	S Pengge	Approximate Interval Between Onset and Death
700	ath certificate	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 manths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at to 9 Unknown	2 Fetal death	3 □Ectopic pr 5 □ Other (sp					23d. Date of deliv Month	ery Day Year
	uires that uires that signed b	þ	Part II. Other significant conditions of	contributing to death bu	t not resulting in th	ne underlying c	ause give	en in Part I.			,	he cause of death?
	The law requir ate has been si page 2 should l	Completed		***************************************					24a. Wa auto pert 1 □ Yes	ormed2	death?	opsy findings available impletion of cause of
78.7	Physician: The la Physician: The la this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:	7		Oth	26. Place of Dea				
	Attending Physic death. sctor: After this by the funeral did	ation; To	1 Yes 2 No  27. Manner of Death 1 Hatural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day	nt 2□ ER/Outpa y 28b. Tim Year) Inju		8c. Injun Wor	Nursing H	ome 5 Res 28d Describe		6 □Other (Special ry occurred	(v)
ä	To the Hospitel or Attendi within 24 hours after death. To the Funerel Disctor: A completely filled in by the fi	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm . (Specify)	, street, factory	r, office		28f. Location City or To	(Street ar own, State	nd Number or Rura e)	al Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa-	nysician: To the best of miner: On the basis of and manner stat	examination and/o	leath occurred or investigation	at the tin , in my o	ne, date and place pinion, death occu	, and due to the rred at the time	e cause(s , date an	) and manner as s d place, and due t	stated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	Z CAD	MD	290	Licens	o number	)	29d. Da	te signed (Month,	Day, Year)
			30 Name and address of person incorporation in the RCBERT SANCE	mpleted cause of de	5 08	rpe. Print)	WII.	D ANG	NUE	EA	STON P	NS 21601
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Local	12				-	

Dorsey Baynham

			1 - For State Registrar	State of Marylan	d / Depa			dental Hyg	_	~ .
	Physic	an	Decedent's Name (First, Middle, Last,					2. Date of Dea Month	Day Ye	3. Time of Death
	/Medi	cal	CCRA JOY AN' 4a. Fecility Name (If not institution, give		LE	4h City Town or	Location of Death	Mar	4c. County of 1	
	Examir	ner	Howard County Hosp			Columbi			Howard	
	Funeral		5, Social Security Number 6. Sec			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey		Birthplace (Stete or Foreign Country)
	Director		554-04-5575 Usual Residence of Decedent	49	Yrs.			May 21,	1954 I	llinois
	yland how		10a. State 10b. County	10c. City	y, Town or Loc	ation			·	10d. Inside City Limits
	Ba-f s	Director	Maryland Anne Arun	del Arno	old					1 ☐ Yes 2 🙀 No
	hours after death with the Maryland turel', or Items 23e or 28e-f show al Examinal must be notified at		10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	·
	death ms 23	Funeral	1349 Jones Station 11. Marital Status	12. Was Decedent Ever in U.	S.   13. W	21012 as Decedent of H	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		American Indian,
9	or Ite	/ Fur	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		Yes, specify Cuba □ Yes 2🕅 No		Rican, etc.)		White, etc.
21215-0036	72 hours after death with the Marylan naturel, or Items 23e or 28a-f show dical Examinet must be notified at	ed by	3 Widowed 4 Divorced	Year or Dates:					Specify:	white
715	⊆ ∰	Completed	(Specify only highest grade Elementary/Secondary (0·12)	o completed)	(Give k	ent's Usual Occupa ind of work done of O NOT use retired	furing most of work	ing	16b. Kind of Busin	ess/Industry
212	filed within 7 Hygiene. wher then "n	Com	12	College (1-4or 5+)	S	ales Cle	rk		Retail	
and	0 = 0 5	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Sumame)	
Maryland	thould id Men marks matic	J.	Randall W. Bramble 19a. Informant's Name/Relationship (Ty		19b Mailing	Address (Street	Edith Al		City or Town Sta	te Zin Codel
	nd 2 salth an 27 ls r trau		Ralph Bramble	,	РО Во		dgely, Ma		21660	10, 210 0000)
Baltimore,	of Hez		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		lace of Dispos				20c. Location - City	or Town, Stete
ij	ment tant: h		*4 ☐Donation 5 ☐ Other (Specify)	unk				4	ocally-B	altimore
Ball	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		21. Signature of Funeral Service License	90		Name and Addres eegle an	s of Facility d Helfent			
	20.7%		23a. Pert1. Enter the disease, or compli	cations that caused the death	PO n. Do not enter	Box 160	Greenst	oro, Ma	ryland 2	21639 Approximate
П	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	Atheruseleval						Interval Between Onset and Death
П	/Medical		resulting in death)	Due to (or as a consequ					7.4.4.20	[ Aug (FE)
9	Examiner	_	Sequentially list conditions,	Due to (or as a consequence						1000
	ned Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dichetes	,	trs				- Roll
o,	ate be executed hysicien and he burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):					
8760,	ate be hysicie	lical		l						
x 68	The law requires that the death certifica tite as been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnal	ncv					
Вох	death c	cian	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 PNo	1 Live birth 2 Fetal	death 3 E	ctopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
P.O.	at the c by the tachec	hysi	9 Unknown	9□ Unknown						
	uires that the signed by to	ρ	Part II. Other significant conditions con			terlying cause give	in in Part I.			e to the cause of death?
oro	k requir teen si s'ould	eted	divolticulosies, vemol	carug amusel	hervin)			1 ☐ Ye		Probably 4 Unknown
Hec	The law cate as t page 2 s	Completed	phylogenhylin hogy de the consequence					24a. Was ar autopsy perform	y prior	autopsy findings available to completion of cause of n?
tal	10	Be Co	25. Was case referred to medical				26. Place of Death		D-No 1 🗆	res 2 No
Ž	Physician: this certificantal director,	ToB	examiner? 1 Des 2 No	ospital: 1 Inpatient 2 📝	R/Outpatient	3 DOA Othe			nce 6 Other (S	Specify)
0 0	ding Pt n. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho	w injury occurred	
Division of Vital Records,	l or Attending after death. Director: Aftel in by the fune	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	me farm stree		′es 2 □No	28f Location /Str	ant and Number o	Rural Route Number,
Ω	al or A s after I Dire d in by	ertii	4  Homicide determined	building, etc. (Specify	)	st, ractory, onlos		City or Town	State)	ngrai nogra rumbar,
	To the Hospital or Attending Physician: Within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death of inve	occurred at the tim stigation, in my op	e, date and place, a inion, death occurr	and due to the ca ed at the time, da	use(s) and manne ite and place, and	r as stated. due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1	Semh	29c. License	number	29	d. Date signed (M	onth, Dey, Year)
			taty a A	y= Ms	J.ME	DB	1473		March 9	3,2004
			30. Name and address of person who co		. , , ,	1 1	1 1		14 6 2	MD 21.42
	Sta	te	31. Date filed (Month, Day, Year)	F. WD 456 32. Registrar's Signat	-	mlock	come wi	J'EIU	Coll Cct	NW 21.42
	Registr		MAR 1 0 2004	12 13	A STATE OF THE PARTY OF THE PAR	61				

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State of Maryland / Department of Health and Mental Hygier Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Monti **Physician** April 12:25 2004 Violet Doris Baronowski /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Cecil 150 Walton Lane North East If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 ☑ F 72 MD 218-26-6093 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits the Maryland 10a. State 10h County 23s or 28e-f ehow the Medical Exercitive rount be notified at 1 ☐ Yes 2 No North East MD Cecil Direct 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 150 Walton Lane 21901 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ltams 2 11. Marital Status Black White etc. within 72 hours after 1 Never Married 2 Married 5 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 🎇 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Tavern 8 Bartender permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: If Item 27 is marked other t any injury or other traumatic avent. In 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nathaniel Smoot Sr. Catherine Wolf ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 150 Walton Lane, North East, MD 21901 Alice M. McGee/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 04-05-2004 1 Burial 2 Cremation 3 Removal from State R.T. Foard Funeral Home, P.A. Rising Sun, Maryland \* 4 Donation 5 Other (Specify) 22. Name and Address of Facility R.T. Fourd Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD 21911 21. Signature of Funeral Segon Licensee Pant. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastalic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 3 ☐ Probably 4 ☐ Unknown 2 □ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 21 No certificate 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient Medical Certification: To 3 DOA 1 Yes 2 ER/Outpatient 27. Mann of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nin 24 hours after death. the Funeral Director: A 2 Accident the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide Hospitel 1 🗹 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 135653 4 5/04 W. High St. Steloy Elkton MA 21 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Singof Hostord MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 0 6 2004 aposte

Physicia	n	1. Decedent's Name (First, Middle,							2. Date of De	ath Day	Year	3. Time of Death
/Medica			haroon Bak						March	7	2004	
Examine	er	4a. Facility Name (If not institution,			Marker !	4b. City, T		Location of Deal		4c. Cour	HICSM	VAD
Funeral		PENINSULA REGIO 5. Social Security Number			. last birthday)	If Under	1 Year	If Under 24 Hrs	8. Date of Birt	h		
Director		219-44-1892	1 <b>→</b> M 2 □ F	50	Yrs.	Months	Days	Hours Min.	(Month, Da) March	y, Year) 14,195	3 N	place (State or Foreig ntry) 1D
pu »		Usual Residence of Decedent  10a. State 10b. County		100.0	ity, Town or Lo	antina						
faryla shor	5		ester	100.0	Berli							10d. Inside City Limit 1 ☐ Yes 2 🔣 N
ours after death with the Maryland real; or Itams 23a or 28a-f show	Completed by Funeral Director	10e. Street and Number				10f. Zip (	Code			10g. Citizen o	of What Cou	
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deat arms	ner	11. Marital Status	12. Was Deceden	t Ever in U	J.S. 13. V	Vas Decede			pecify Yes or No- to Rican, etc.)	14. R	ace - Amen	
or it.	y Fu	1 Never Married 2 Marrie	d Yes 2	] No		Yes 2			io moan, etc.)		lack, White,	eic. Nite
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r the	E	Elementary/Secondary (0-12)	College (1-4or	r 5+)	Diese					City	Gover	nment
2 should be filed within 72 hours att and Mental hygiene. Is marked other then "natural", or aumatic event, it a Medical Exemi	ge C	17. Father's Name (First, Middle, La	ast)					18. Mother's Nai	me (First, Middle.			
ould be Mental Marked o	To Be	Marion L. Bak	er					Ann D	isharoor	}		
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene Important: If item 27 is marked other then "natur any injury or other traumatic event, It a Madical once.		19a. Informant's Name/Relationship	p (Type, Print)		-				ıral Route Numbe		n, State, Zip	Code)
1 and Health em 27 thar tr		Judy R. Baker 20a. Method of Disposition		20h	92 4 Place of Dispos	Pitts	Rd.	, Berlin	Md. 2		Oibs as Te	
nt of h		1 Burial 2 Cremation 3			cemetery crem	atory or oth	her place	m 3-8-	04 F	20c. Location	•	
artmer artant njury	1	*4 ☐ Donation 5 ☐ Other (Special Service Light)		Cu				1			Ji u, D	eiaware
Depa Impo any ir		1/4	Quetal.		22	The E	Burb	age Fur	eral Hor	ne		
		23a. Parti. Enter the disease, or conshock, or heart failure. List or	omplications that cause	ed the dea	th. Do not ente	r the mode	of dying	n SI., , such as cardiad	Berlin, No or respiratory are	M. 218 rest,	311	Approximate
nysician		Immediate Cause (Final										Interval Between Onset and Death
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physis the			0									
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e atte	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant a			Ectopic pred Other (spec					lonth	Day Year
by th	hys	9 Unknown	9□ Unknown									
p ed	Ď	Part II. Other significant condition	s contributing to death	but not res	sulting in the un	derlying cau	use give	n in Part I.				ne cause of death?
een s	ted								1 U Y	es 2 No	3 Prob	ably 4 2 Unknown
£ 0	Completed								24a. Was a autops	in 24b	. Were autor	psy findings available npletion of cause of
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2 00 00	ca	(Check only 2   Medical Ex	Physician: To the best caminer: On the basis	t of my kno	owledge, death	occurred at	the time	, date and place	, and due to the c	ause(s) and m	nanner as st	ated.
Funeral funeral tely filled		one)	and manner s	tated.			License					
thin 2- hours the Funera	e l	20h Signature and title of contried										
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			For State Registrar	State of Ma	aryland /	Depa <i>Cer</i>	rtment of H	ealth ai Death	nd Mental Hyg	giene 200	4 12964
	Dhuaiair		1. Decedent's Name (First, Middle,						2. Date of Dea Month	Day Year	
	Physicia /Medic		George	C	izek				April	2, 2004	
	Examin	er	4a. Fecility Name (If not institution,	_	207		4b. City, Town, or			4c. County of Dec	
			101 Wesley Dr 5. Social Security Number		. 207 e (In yrs. last bi	irthday)	La If Under 1 Year	Plat		Char	
	Funeral Director		119-22-7273	1 M 2 F	87	Yrs.	Months Days	Hours	Min. (Month, Day February		rthplace (State or Foreign country) New York
	and w	1	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Lo	cation				10d. Inside City Limits
	Aarylis f sho	5	MD Charl	00	La I	D1 a f	- 2				1X1Yes 2 □ No
	the t	rect	10e. Street and Number	.03	па і	. та	10f. Zip Code			10g. Citizen of What C	Country?
	3a or	Funeral Director	101 Wesley Dr	rive, Apt.	207		20646	)		USA	
	death ms 2	nera	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. V	Vas Decedent of Hi	spanic Origi	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Wh	
ထ္	after or ita	Ē	1 Never Married 2 Marrie	Armed Forces? d 1 □ Yes 2 □ N If Yes, Give	10	1		Specify:	r don't r nodin, dien,		White
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21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or itams 23a or 28a-f show event. I're Medical Evertires must be notified at	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	lent's Usual Occupa kind of work done d DO NOT use retired,	lurina most (	of working	16b. Kind of Busines	symdustry
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Maryland	should be nd Mental marked c	To B	Frank Cizek					Her	mina Kra	hulik	
ary	should and Men smarke sumatic		19a. Informant's Name/Relationshi	p (Type, Print)	19	b. Mailin	g Address (Street a	and Number	or Rural Route Numbe	r, City or Town, State,	Zip Code)
	s 1 and 2 should I Health and Mer Item 27 is marke other traumatic		Edith Cizek/	Wife	1(	1 V	desley D	r. A	pt. 207,L	a Plata,	MD 20646 -
ore	of Hea of Hea if item or otha		20a. Method of Disposition 1 Burial 2 ☐ Cremation	3 □Removal from State	cemete	ery, cren	natory or other place	9) ¦	. 10		
Ë	Pag tment tant:		`4 □Donation 5 □ Other (Sp.		Mary) M00945		l Vetera	-	the second secon	heltenha	
Baltimore,	permit. Pages Department of It Important: If Ite any injury or of		21. Signature of Funeral Service L	5101		2	AREHARI	ECH	OLS FUNER	AL HOME,	P.A.
			23a. Part1. Enter the disease, or called a second fallows.	complications that caused	I the death. Do	not ente	P.O. BO er the mode of dying	X 56	/ , LA PLA ardiac or respiratory ari	TA, MD 20	Approximate
			shock, or heart failure. List o Immediate Cause (Final	illy offe cause off cace-in	RURO	- ^	Sculpe !	Droi	chait		Interval Between Onset and Death
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	The law requires that the death certificate has been signed by the attending plagge 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other (specify)			Month	Day Year
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	res that igned I be det	by F	Part II. Other significant condition	is contributing to death b	ut not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did to		to the cause of death?  Probably 4 Unknown
ord	w require been si should I	ted	Trave	en sien					-	7	
Records,	e law has b	Completed							24a. Was a autop	sy prior to	autopsy findings available completion of cause of
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Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ♣ No	Hospital:	ent 2 ER/C	utnatien	t 3 DOA Othe		of Death <i>(Check only or</i> sing Home 5 X Resid		ecify)
of		<del> -</del>	27. Manner of Death	28a. Date of Inju	ry 28b.	Time of		-	•	ow injury occurred	ouny,
io	E - E =	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	y / Gai/	injury		Yes 2⊡N	lo		
Division	I or Attanding after death. Diractor: After I in by the fune	Certification:	3 Suicide 6 Could n 4 Homicide determine	ot be ned 28e. Place of Inj building, et		farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	spital		29a. Certifier 1 Certifying	Physician: To the best	of my knowledg	ge, death	n occurred at the tim	ne, date and	place, and due to the o	ause(s) and manner	as stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical E	xaminer: On the basis or and manner sta		ind/or in	vestigation, in my or			gate and place, and du 29d. Date signed (Mor	
	To To		255. Signature and title or certifier	Xa. 1/	Kly		020	35	2	4/2/04	,
M	P591VA		30. Name and address of person y	300/ 8	5926 W	(Type,	Print) Yerd	e4	Cliva	on MD	
	Sta Regist	ate	31. Date filed (Month, Ray Year)	5 2004 32. Registr	ar's Signature	ti.	Specter				

			1 - For State Registrar	State of Ma	aryland	/ Depa	artment of rtificate o	Health f Death	and N	Mental Hyg	iene	2004	12965
2	Dharaisi	j.	1. Decedent's Name (First, Middle,	Last)						2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		Thelma Louis	e Cooksey						March	31,	2004	8:00 p <sup>M</sup>
	Examin		4a. Facility Name (If not institution,				4b. City, Town					ounty of Death	
- 4		r Africa	7 Jenkins Dr		- //	4 6 1 46 45 3	India If Under 1 Ye	an Hea	ad 24 Hrs.	0.0 . (0:0		harles	
<b>3</b>	Funeral Director		5. Social Security Number 216-37-6071  Usual Residence of Decedent	7. Age 1  M 2	e (In yrs. las		Months Day		Min.	8. Date of Birth (Month, Pay, April	12,	1925	place (State or Foreign ntry) Maryland
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Man,	to	Maryland Char	cles	Ind	ian	Head						1X Yes 2 □ No
	or 284	Director	10e. Street and Number				10f. Zip Code	9		10	0g. Citize	n of What Cou	ntry?
	hours after death with the Maryland tural; or Itams 23e or 28e-f show al Exercitival must be ricititied at	al	7 Jenkins Dr	ive			20	0640			U	.S.A.	
	tams	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of f Yes, specify C	of Hispanic Or uban, <mark>Mexi</mark> ca	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14.	. Race - Ameri Black, White,	
30	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Veridowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates:	40		1 □ Yes 2 💆 N	lo Specify.	:		S	pecify: Whi	i + 0
3	tural	edk	15. Decedent's			16a. Deced	dent's Usual Occ	cupation			16b. Kind	of Business/Ir	
<u>င</u> ်	within 72 ene. than "nai	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5		(Give	kind of work do DO NOT use ret	ne during mos ired)	st of work	ing			,
7	d with	mo	11	College (1940) 3	17)	Hom	emaker				Her	Home	
9	be filed ital Hygi od other event, I	Be	17. Father's Name (First, Middle, La	st)				18. Moth	er's Nam	e (First, Middle, N	fa <i>iden S</i> u	imame)	
<u>   </u>	should bend Ment and Ment amarked umatic e	2	Joseph Is	stvan						Buckle			
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship							al Route Number,			20011
	s 1 and f Health item 27 other to		Mary L. Burk	e/daughte									cco, MD
Baltimore,	8° = 5		20a. Method of Disposition 1 Rurial 2 Cremation 3	☐Removal from State			sition (Name of natory or other p	A4.	pril	. 6, 200		tion - City or To	own, State
	nut. Pages partment of cortant: If it injury or of		*4 Donation 5 Other (Spe		st.		cles Ce	emeter	СУ		Indi	an He	ad, MD
g	Depa Impo any i		21. Signature of Funeral Service Lie	14	MOOC	60 4		ress or Facili	w Wi	lliams	Fun	eral	Home, PA
	90		23a. Part1. Enter the divease, or co shock, or hear talure. List or	omplications that caused	the death.	Do not ent	er the mode of d	w LHOP.	ne F	or respiratory arre	nala st.	іп неа	d, MD 2064 Approximate
	Obvoision		Immediate Cause (Final	nty one cause on each lin									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a			iac C	1 Ca H					
	Examiner				Jens,0		and						
н		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Oue to (or as a	a consequer	nes of).						- 1	
	cuted nd transi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Diale	7		, 11, hu	and					
<b>,</b> ρΩ,	ate be executed hysician and he burial-transit		resulting in death) Last	Due to (or as a		,							
687	cate b	dical		a Hyer	mpid	Le M. 0	·						
	The law requires that the death certificat tile has been signed by the attending phy age 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnance	v					024	I. Date of delive	
X R Q	atter atter	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3□	Ectopic pregnal Other <i>(specify)</i>				230	Month	Day Year
o.	t the de by the a tached	nysi	1 □ Yes 2 🔼 No 9 □ Unknown	9□ Unknown			(//						
J	res that igned k be deta	y P	Part II. Other significant conditions	_	ut not resultin	ing in the ur	nderlying cause	given in Part I		23e. Did tob	acco use	contribute to ti	he cause of death?
ğ	w require been sig should b	ed t	Alcahalism	<b>\</b>						1 XYe	s 2 🗆 N	No 3□Prob	oably 4 Unknown
Hecords,	aw re as be 2 sho	piet								24a. Was an		4b. Were auto	psy findings available
ř	The l	E O								autopsy perform 1 Yes 2	ed?	death?	mpletion of cause of 2□ No
Vital	ician: certifica rector,	Be (	25. Was case referred to medical examiner?							(Check only one	)		
0	or Attending Physician: ifter death. Diractor: After this certific in by the tuneral director.	၉	1 ☐ Yes 2 No	Hospital: 1 Inpatier		NOutpatien	t 3□ DOA	Other: 4 □ Nu		me 5 Resider			y)
Ĕ	ding P h. After I tunera	ion:	27. Manner of Death 1 ANatural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28	Bb. Time of Injury	28c. In			28d. Describe how	w injury o	ccurred	
S	ttend Jeath tor: /	cat	2 Accident investigat 3 Suicide 6 Could no	be -	and At home			Yes 2	-	006			10
Division	al or Attendir after death. I Diractor: Al d in by the tu	Certification:	4 ☐ Homicide determine	28e. Place of Inju building, etc	. (Specify)	e, iaim, str	eet, ractory, onto	e		28f. Location (Str. City or Town,		rumber or Hura	I Houte Number,
_	Hospital	aj C	29a. Certifier 1 Certifying	Physician: To the best of	of my knowle	edge, death	occurred at the	time, date an	nd place.	and due to the car	use(s) an	d manner as s	tated
	To the Hospital of within 24 hours all To the Funeral D completely filled in	ledical	(Check only 2 Medical Ex	on the basis of and manner sta	examination	n and/or inv	estigation, in my	y opinion, dea	ith occurr	ed at the time, da	te and pla	ace, and due to	the cause(s)
	To th withir To th compi	Me	29b. Signature and title of certifier	/			29c. Lice	nse number		29		igned (Month,	Day, Year)
1			15 21				13	342	6		4-	1-04	
	_		30. Name and address of pers in M	o completed cause of de	eath (Item 23	3a) (Type,		2 12	4				
M	P5		B. Larry Jenki	ns, Jr.,	MD; 1	111 I	agrand	je Ave	enue	; LaPla	ta,	MD 20	646
1	Sta Registr	4	31. Date filed (Month, Pay, Year)	7 2004 Registra	ar's Signatur	10	frest s						
	riegisti	<b>.</b>				-	Contraction of the second						

	•	•	•	aryland / D	c Indelible Ink repartment of I Certificate of	Health and N	Mental Hyg	_	12966
Physici		1. Decedent's Name (First, Middle, Last)  John Robert Cor	nover,	Sr.			2. Date of Dea Month March	31°, 2004	3. Time of Death 9:59P M
/Medic Examin		4a. Facility Name (If not institution, give sta Civista Me		enter	4b. City, Town, LaP1	or Location of Death ata		4c. County of Deat	rles
Funeral Director		200-01-6/35	4 00 5	e (In yrs. last birt 87	hday) If Under 1 Year Months Days		8. Date of Birtl (Month, Day JUly	9. Birt 11, 1916 I	hplace (State or Foreign Juntry) Pennsylvania
faryland f show	ŏ	Usual Residence of Decedent  10a. State  10b. County  Maryland Charles		10c. City, Towr	or Location n Head			·	10d. Inside City Limits 11 Yes 2 □ No
with the N Sa or 28s-	I Director	10e. Street and Number 16 Kenwood PLace			10f. Zip Code 206	540		10g. Citizen of What Co	puntry?
72 hours after death with the Maryland natural', or items 23e or 28e-f show nical Examinar rount be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent   Armed Forces?   1 Yes 2 M   If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cul		pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
4 24	Completed	15. Decedent's Educa (Specify only highest grade	ation completed) College (1-4or 5		Decedent's Usual Occu (Give kind of work done life. DO NOT use retin Mechanic	during most of work	king	16b. Kind of Business	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any injury or other traumatic event, Inn Means once.	To Be C	17. Father's Name (First, Middle, Last)  Ross Percy Conove				Lucy	τ	Maiden Sumame)  Jnknown	7.0.4
and 2 sho ealth and m 27 Is m		John Robert Conove		1	6 Kenwood I	Place, Ind	lian Hea	d, Md. 2064	0
Pages 1 ment of Hi ant: If Itan		20a. Method of Disposition  1 ☐ Surial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemeter	Disposition (Name of y, crematory or other plants  ty Memoria	L Gargeris	,2004	WAldorf, M	
permit. Departimont Import		21. Signature of Funeral Service Licemen	<u> </u>	M00668	4270 HAW		, India	n Head, Md.	20640
Physician /Medical Examiner  pe executed physician and phy	al Examiner	23a. Part 1. Enter the disease, or complice shock, or hear failure. List only one Immediate Cause (Final disease or condition resulting in death)  a.  Source tist, list condition of any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence  A M M T  a consequence  A M M  a consequence	DATH			<u> </u>	interval Between Onset and Death A WK3  + Yuna
The Cold ds, T.C. BOX 0017. The law requires that the death certificate I ale has been signed by the attending physipage 2 should be detached for use as the I page 2.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Sc. If yes, outcome 1 Live birth 4 Pregnant al	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)			23d. Date of de Month	livery Day Year
w requires that been signed b should be deta	by	Part II. Other significant conditions conf	tributing to death b	out not resulting i	n the underlying cause g	given in Part I.		obacco use contribute to Yes 2□No 3□P	4
	Completed						24a. Was autop perfo 1 🗆 Yes	an 24b. Were at prior to death? 2 No 1 Yes	utopsy findings available completion of cause of
Physician: this certifica at director, p	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	ent 2□ER/Ou	Thatient 3 DOA	other: 4 Nursing H	ith <i>Check on</i> come 5 ☐ Resid	one dence 6 □Other (Spe	ocify)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death  1.7 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju	y Year)	Time of njury M 28c. In W 11	Yes 2 No		how injury occurred  Street and Number or R	ural Route Number
pital or Ai		4 Homicide determined	building, e	tc. (Specify)		ž.	City or Tov		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Alter th completely filled in by the funeral	Medical			of examination ar	d/or investigation, in my 29c. Licé		irred at the time,	date and place, and due	e to the cause(s)
mp6		30. Name and address of person who co George H Wather		l345 P∈	(Type Pint) embrooke S		te 103	Waldorf,	MD 20603
	ate trar	31. Date filed (Month, Ray Kear) 7	2004 <sup>32. Red \$1</sup>	rar's Signature	A Apollo				

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For Stete Registra Certificate of Death Reg. No. 2 () [] [ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ANNIE HORTENSE HILL CHISLEY APRIL 8, 2004 7:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 11200 ACKER ROAD NEWBURG CHARLES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | MRCH 22,1914 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2\ \ F 213-40-7867 90 Yrs. Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23a or 28e-f show the Medical Examinar must be notified at 1 TYes 2 □ No MARYLAND CHARLES NEWBURG Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11200 ACKER ROAD 20664 UNITED STATES filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No þ 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry 3RD. GRADE College (1-4or 5+) DOMESTIC PRIVATE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental 27 is marked of treumatic ever GEORGE A. HILL ELLA HEMSLEY HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tre VERNON CHISLEY / NEPHEW 6001 WALNUT STREET, TEMPLE HILLS, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. HOLY CHOST CHURCH CEMETERY APRIL 16, 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) ISSUE, MARYLAND 21. Signature of Funeral Service Lipproce 22. Name and Address of Facility THORNION FINERAL HOME, P.A. 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MO0583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) O. Box 68760. Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has triector, page 2 s autopsy performed of Vital or Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Vatural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) -8-04 050100° cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended#26 perFH/FCHD/SL/3/24/04 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** Delfino Roman Carrillo 18, 2004 March 6:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Shady Grove adventist Hospital Rockville Montgomery If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral**  Birthplece (State or Foreign Country) Months Days 18XM 2□ F Yrs. Director 449-43-4457 64 Dec. 28, 1939 Texas Usuel Residence of Decedent parmit. Peges 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury or other traumatic averages. 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 1K Yes 2 □ No Funeral Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Park Avenue 20877 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 11XXYes 2□No *Specify:* Mexican Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) (disabled) n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jose A. Carrillo Bernarda Roman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Elisa Chavez / Sister 1705 Castle Rock Rd., Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Mar. 20, 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 5 Other (Specify) Resthaven Crematory 4 Donation 2004 Frederick, Maryland Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Funera S vice Licenses 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the diseas shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Listonly one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical MARIONOS Y03 22 20 4 3213B1 Examiner Due to (or as a consequence of): Examiner O GO SECONAR 1415381 F bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ettending physician and for use es the bunal-trar Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of): is certificata has been signed by the director, page 2 should be dateched Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 TNo 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed' TIYES 2LAND 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide crifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, within 24 hours aftar death.

To the Funeral Director: After this completely filled in by the funeral To the

> State Registrar

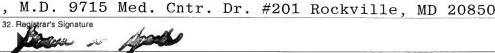
(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 2004 MAR 23

Anushiravan Dadgar,

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)





29c. License number

H0051280

29d. Date signed (Month, Day, Yeer)

3-19-Lecon

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 12, 2004 10:50 RM CARROLL THERESA CATHERINE /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 🙀 F 176-26-8433 Director Feb. 17, 1936 New Jersey 68 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be nutified at 1 ☑ Yes 2 ☐ No Funeral Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Motter Avenue, Apt. 609 21701 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Food Service treumatic event, permit. Pages 1 and 2 should be tile Department of Health and Mental Hy Important: If item 27 is marked othi any injury or other treumatic event gode. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) (unobtainable) (unobtainable) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Carroll / Son 714 Columbia Avenue, Lancaster, PA 17603 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 16, 20a Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory 2004 Frederick, Maryland Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 21. Signature of Funeral Service Licenses 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alcoholic 12 Days Pancocatitis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner anding physician and use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal dea

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy atter for u Month Day 5 Other (specify) been signed by the should be detached 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No pesten sion autopsy performed; 2 No Medical Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After the funeral 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deati To the Funeral Director: completely filled in by the filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signa and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D51643 Shah Hiren, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thonson D 32. Register's Signature Thomas redenich mi 31. Date filed (Month, Day, Year) State MAR 1 7 2004 > Registra

			1 - For Stata Registrar		ryland / Dep <i>Ce</i>	artment of H	lealth and N Death		iene 004	12971
	Physici /Medi		Decedent's Name (First, Middle, Las     Louise Alice	•				2. Date of Death Month	Day Year	3. Time of Death
	Examir		4a. Fecility Name (If not institution, give SACRED HEART	Mospiti		Cumb	er Location of Death		4c. County of Deat AlleGar	
e elbor	Funeral Director		5. Social Security Number 6. Security Number 217–07–7482	7. Age ☐ M 2/ONF 83	(In yrs. last birthday) Yrs.	If Under 1 Year   Months   Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 2 1	9. Birth 920 Mar	hpidce (State or Foreign Junity) Yland
	Maryland s-f ehow	tor	10a. State 10b. County MD. Allega	ny	10c. City, Town or Lo Barto					10d. Inside City Limits 1
	th with the 23a or 28d	al Director	10e. Street and Number 19203 German	St.		10f. Zip Code 2152	21	10	og. Citizen of What Co United St	•
920	n 72 hours after death with the Maryland "natural", or Items 23a or 28e-f show colleal Exeminat mat be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	Was Decedent of Hi If Yes, specify Cuba ↑ Yes 2 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
21215-0036	e * 3	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) unknown	ucation de completed) College (1-4or 5+	(Give	dent's Usual Occupa h kind of work done of DO NOT use retired NUTSES AIC	turing most of work )	ing 1	6b. Kind of Business/	
Maryland ?	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importants if Item 27 is marked other then any injury or other traumatic event, Item DECE.	To Be C	17. Father's Name (First, Middle, Last) Phillip Vi	nci			Ethel		,	
	1 and 2 shu Health and em 27 is m		19a. Informant's Name/Relationship (T Shirley Ashby/ da		23909	) Keplinge			City or Town, State, Z Maryland	(ip Code) 21521
altimore,	permit. Pages 1 are Department of Heal Important: if Item any injury or other once.		20a. Method of Disposition  1 ★ Surial 2 □ Cremation 3 □ i  4 □ Donation 5 □ Other (Specify,		20b. Place of Disposition Commetery, cred Laurel Hi	osition (Name of matory or other place ill Cemete	e) ' 02/	20/	oc. Location · City or Barton, Ma	
Bal	permit. Departi Import. any inj		21. Signature of Funeral Service Licens  7. Wuyne  23a. Part1. Enter the disease, or comp	Bol	1	2. Name and Addres	st., We	sternpor	eral Home : t, Marylan	
8760,	water be executed // Medical water w	lical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of):	myod ory Z	ardéae a'elur	e	arclim)	Interval Batween Onset and Wath
P.O. Box 6	Attending Physician: The law requires that the death certificate be executed redeath, redeath, and additions the certificate has been signed by the attending physician and stors there this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliving Month	very Day Year
	n requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause give	n in Part I.		acco use contribute to	
Vital Records,	n: The law requificate has been or, page 2 should	e Completed	25. Was case referred to medical						prior to co death? No 1 \(\to\) Yes	opsy findings available ompletion of cause of
Division of Vi	ending Physician: The I sath. or: After this certificate ha he funeral director, page	ToB	examiner?  1  Yes No  27. Nanner of Veath  1 X Natural 5  Pending  2 Accident investigation	1 Inpatient 28a. ate f Injury (Month, Day	28b. Time of	28c. Injury Work	r: 4 🗆 Nursing Ho	n (Check only one. me 5 ☐ Residen 28d. Describe how	ce 6 Other (Speci	fy)
Dİ	i i ji de	Certification:	3 Suicide 6 Could not be determined	building, etc.		52		City or Town,		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one) /2   Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or inv	vestigation, in my op	inion, death occurr	ed at the time, dat	se(s) and manner as s e and place, and due t	to the cause(s)
	T W T		29b. Signature and title of certifier	1		29c. License	5463	290	d. Date signed (Month,	pay, Year) 7004
	Sta		30. Name and address of person who of a state of the stat	90 main	th (Item 23a) (Type,	Print)	mport.	110 6	USUS	
	Registr	ar	3000 30 3	. A many	A Charles Ones					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Wayne Martin Casteel March 12, 2004 1:47 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital Oakland Garrett If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director Feb 19, 236-46-8369 71 West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or Items 23a or 28a-f show treumatic event, the Madical Examinations as the notified at Director 1 ☐ Yes 2 X No PA Somerset Confluence 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15424 Rt 523, PO Box 195 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status e filed within 72 hours atter il Hygiene. other than "neturel", or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No white à Specify: 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 th Coal Miner Coal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil iment of Health and Mental H tent: If item 27 is marked otl Be George Casteel Nellie Sisler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree Jeremiah J. Casteel/son PO Box 254, Dixon Rd., Friendsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Parnell Cemetery, March 15, 2004 Cuzzart, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 21. Signature of Furtheral Service. 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line.

Immediate Cause (kinal disease or condition resulting in death)

a. Pneumonia Approximate Interval Between Onset and Death Physician l month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated excesses) Alcoholic encephalopathy months Examiner and I-transit The law requires that the death certificate be executed Chronic alcoholism that initiated events resulting in death) Last years Due to (or as a consequence of). attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 ☐ No 1∐ Yes 2 No Hospitel or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 No After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours af

To the Funeral D

completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/12/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Johnson, M.D., 311 N. 4th St., Oakland, MD 31. Date filed (Month, Dav. Year) 32. Registrar's Signature State MAR 1 8 2004 Registrar

			For State of Registrar	f Maryland / [	Department of F Certificate of	Health and M <i>Death</i>	ental Hygie	_	12973
	Physici		1. Decedent's Name (First, Middle, Last) Charles Christopher	Coates			2. Date of Death Month April	Day Year 2 2004	3. Time of Death 5:00 p <sup>M</sup>
	/Medic Examir Funeral Director		4a. Fecility Name (If not institution, give street and nun 721 Hughlett St. 5. Social Security Number 6. Sex 213-26-1468	7. Age (In yrs. last bin	Cambr	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye June 22,	4c. County of Death  Dorche	
	2	'n	Usual Residence of Decedent  10a. State 10b. County  MD Dorchester	10c. City, Town		ridge	oure 22,		10d. Inside City Limits 1'X'Yes 2 □ No
}	3a or 28a-	al Director	10e. Street and Number 721 Hughlett St.		10f. Zip Code	21613	10g.	Citizen of What Cou	intry?
5-0036	omenin received and observed the wayses righted.  righted instruction it is the second of the modified at the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes  If Yes, Giv	re '	13. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Spe an, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: W	
9500-51215	one. than "natura	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Welder	pation during most of workir d)	ng .	Kind of Business/Ir	,
חם	avent,	To Be Co	17. Father's Name (First, Middle, Last)  Charles Freeman Coates		werder		(First, Middle, Maid • Christo	den Sumame)	I lab.
Maryla	and and and and and and and and and and		19a. Informant's Name/Relationship (Type, Print)  Christian Schnoor gra	4	. Mailing Address (Street P. O. Box 15				
aitimore,		0.7	20a. Method of Disposition  1 ABurial 2 Cremation 3 Removal from 5  4 Donation 5 Other (Specify)	20b. Place of cemeter	Disposition (Name of y, crematory or other place	D)	ate 20c.	Location - City or To	own, State
Bait	Department of Important: If eny injury or once.		21. Signature of Funeral Service treensee		22. Name and Addre	ss of Facility The	omas Fune	ral Home	P.A.
	hysician /Medical		23a. Part J. Enter the disease, or complications that ce shock, or heart failure. List only one cause on earlier disease or condition resulting in death)	ach line.	envescheratur	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
58/6U,	physician and strength strength and strength	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequence of					
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ords, P.O	been signed by should be deta	by	Part II. Other significant conditions contributing to de	ath but not resulting in	n the underlying cause giv	en in Part I.		o use contribute to the	he cause of death?
I Mec	ate has b	Completed					24a. Was an autopsy performed 1 Yes 2 2	prior to co death?	psy findings available mpletion of cause of
- 3	h. After this certificate funeral director, pag	tlon; To Be	27. Manner of Death 28a. Date of (Month)		ime of 28c. Injur njury War	26. Place of Death  er: 4 Nursing Hom  y at k?  Yes 2 No			y)
DIVISION PLOT Attending	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Certification;	3 Suicide 6 Could not be	of Injury - At home, faring, etc. (Specify)	rm, street, factory, office		Bf. Location (Street City or Town, Sta	and Number or Rura ate)	I Route Number,
Hospi	n 24 hour na Funera	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the ba and mann	icie of avamination and	dor invention in me a	-i death	al and also a to a local		**
T	withi To the	M	and mann and	wuch n	DOU	44282	29d. [	Date signed (Month,	Day, Year)
			30. Name and address of person who completed cause	of death (Item 23a) (ID 44/0 /	Type, Print) Buchplans	pt Rd.	O+FORD	mo 21	654
-	Sta Registr		31. Date filed (Month, Day, Year) APR 0 6 2004	gistrar a Signature	It books	,			

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 1

						Cert	ificate of	Death		Reg. No.	04	12:	914
	Dhuninia		1. Decedent's Name (First, Middle, Last	)					2. Dete of Dee Month	Dev	Year	3. Time of I	Death
1	Physicia /Medic		Mildred Virginia	Crocker					March		2004	2:45	AM
1	Examin	er	4a Facility Name (If not institution, give					4b. City, Town, or	Location of Deeth				
			Ruxton Health of 5. Social Security Number 6. Sec	Denton	(fn yrs. last b	inthodos ()	If Under 1 Year	Denton If Under 24 Hr.	S R Date of Rin	Caro		an /Ctata o	r Comian
E-	Funeral Director			IM 21XF	92	Yrs.	Months Deys			1911	Maryla Maryla	ce (State or y) and	Poreign
	Mand Mand		10a. Stete 10b. County		10c. City, Tov	wn or Loca	ition				100	d. Inside City	y Limits
	Man	ģ	Maryland Carolin	ne	Ridg	ely						1 🗆 Yes	2 🕅 No
	or 28	ž į	10e. Street end Number				10f. Zip Code			10g. Citizen of V		y?	
	th wi	al	22840 Peaviner Ro	1			2166				S.A.		
Baltimore, Maryland 21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or terms 23a or 28e-f show ant, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Merried 2 ☐ Married  3 ☆ Widowed 4 ☐ Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:		1	as Decedent of l Yes, specify Cub ☐ Yes 2 X No		Specify Yes or No- rto Rican, etc.)	Blac	e - America k, White, et Blac!	ic.	
5-0	natur dical	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	166	(Give ki	nt's Usual Occu	during most of we	orking	16b. Kind of Bu	isiness/Indu	stry	
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Z	should mark metic	2	19e. Informant's Name/Relationship (T)	rpe, Print)	19	b. Mailing	Address (Stree	<u> </u>	Rural Route Numbe	r, City or Town,	State, Zip C	code)	
Z	end 2 seelth er n 27 la		Walter Ringgold	Cousin		22840	) Peavir	ner Rd I	Ridgely,	MD 216	60		
re,	ーチをお	Ì	20e. Method of Disposition		20b. Place cemete	of Disposi	tion (Name of tony or other pla	ace)	Date	20c. Location -	City or Tow	n, State	
m	Peges nent of I int: if ite		1 🕅 Burial 2 □ Cremetion 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State			netery		March 30 2004	Gre	ensbo:	ro. MI	)
alti	permit. Pege Depertment Important: if any injury or once.		21. Signeture of Funeral Service Licens	98	001001			ess of Facility	nbein Fun				
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oʻ	The law requires that the death certificate be executed ate has been signed by the attending physicien end pege 2 should be detached for use es the bunel-transit	Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that is listed asset)								į		
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of Vital Records,	v requires that the death ce been signed by the atlend should be detached for us.	Completed by Physician/								en autopsy	24b. Wer	e autopsy fir lable prior to	ndings
Ö	w req	Set							репо	med?	com	pletion of ca eath?	
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ta		Be C	25. Was case referred to medical					26. Place of De	eath (Check only o	. (			
1	Physician: r this certific ral director,	2	exeminer?	lospitel: 1 ☐ Inpatien	1 2 ER/C	utpatient	3□ DOA Of	ther: 4 Nursing	Home 5□ Resid	ence 6 Oth	er (Specify)		
ion o	£ 50		27. Manner of Death 1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Inju Wo M 1	ork? ⊇Yes 2 □ No	28d. Describe h	ow injury occur	ed		
Division	i or Atter after dez Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	ry - At home, t (Specify)	arm, stree	t, factory, office		28f. Location (S City or Tow	Street and Numb m, State)	er or Rurai	Route Numb	ber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical C		sicien: To the best of ner: On the basis of e and manner state	examination a								)
	Withir To th	Me	29b. Signature end title of certifier	N.		10		se number		29d. Date signer	/	ay, Year)	
			57/4	M	.1	10	00	04753	4	3/24	104		
			30. Name end address of person who co	empleted ceuse of dea	eth (Item 23a)	(Type, P							
				0 Market	- 23	nton	MD 21	629					
	Sta	te	31. Date filed (Month: Day 2 est) 20	32. Régistrar	's:Signalure	0.3.5	September 1						

DHMH 16 Rev 6/95

Registrar

-2	2101		1 - For Unpend Item#23a	State of Maryla ,27,28a-f, Fer M	nd / Dep	ortment of l	Health and	Mental Hygi	iene 200	)4 1297:
	Physici		1. Decedent's Name (First, Middle, Las.		001	uncate of	Death	2. Date of Death Month	Day Ye	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give JOHNS HOPKINS HOS				r Location of Death		26, 2004 4c. County of D	
	Funeral Director		5. Social Security Number 6. Sec. 213-92-6119	ex 7. Age (In yrs ⊈M 2□ F 2!		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 25	9. 1978 Ma	Birthplace (State or Foreign Country) aryland
	e Maryland ta-f show	ctor	Md. 10b. County Md. Montgome		ity, Town or Lo					10d. Inside City Limits 1    Yes 2   No
	23a or 26 ust be no	Funeral Director	10e. Street and Number 6 Mills Road			10f. Zip Code	20877		g. Citizen of What United St	
020	d within 72 hours after deeth with the Maryland jiene. r than "natural", or Items 23a or 28a-1 show Itle Madical Examiner must be notified at	by	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I ☐ Yes 27 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	mencan Indian, Thite, etc. White
1213-0036	within 72 ho ene. then "natur ne Madical	Completed	15. Decedent's Edu (Specify only highest grad	cation de completed) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occup kind of work done OO NOT use retired	ation during most of won d)	king	6b. Kind of Busine	
ylandz	e filed al Hygi other vent, I	To Be Co	12 17. Father's Name (First, Middle, Last) Charles M. Cook		110000			e (First, Middle, M 1a Ward		5
c, Mar	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		19a. Informant's Name/Relationship (T) Charles M. Cook ( 20a. Method of Disposition	(Father)	8924	N. Westla	and Dr.	Gaitherst	ourg, Md.	20877
saltimore,	artment of lorrant: If its injury or 6		1 X Burial 2 ☐ Cremation 3 ☐ F  *4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	Pa	rklawn	sition (Name of patory or other place Memorial	Pk. 200	30,	ockville	
Ö	Depared Important Importan		23a. Parti. Enterprise diseased, or complete principal diseased, or complete diseased, o	Wiff	1	O East De	eer Park	Dr. Gaith	nersburg,	Md. 20877
Ass	Physician percented /Medical physician and purial-transit the purial-transit	Ical Examiner	shock, or beart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or	quence of): quence of):					Interval Between Onset and Death
.C. 504 001	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funded Director: After this certificate has been signed by the attending physicien and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown		I death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
- 5	w requires that been signed b should be deta	by	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the un	derlying cause give	n in Part I.		cco use contribute	to the cause of death?
	ding Physician: The law re h. h. h. h. h. h. Atter this certiticate has be funeral director, page 2 shr	Completed						24a. Was an autopsy performe	d? death?	
*	ysiciar is certit directo	Го Ве	25. Was case referred to medical examiner?  1 X es 2 No	lospital:	ER/Outpatient	3₹1 DOA Othe	-	n <i>(Check only o</i> ne) me 5 ☐ Residenc	ea 6 Flother (Se	
2	tiending Ph Jeath. tor: Atter th the funeral	cation; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 3/26/04 found	28b. Time of Injury	28c. Injury Work	at ? 'es 2 XNo	28d. Describe how unknown	injury occurred	
2	To the Hospital or Attendir within 24 hours after death.  To the Funerel Director: At completely tilled in by the fu	al Certific	4 Homicide determined  29a. Certifier 1 Certifying Phys	28e. Place of Injury - At he building, etc. (Specification in house sician: To the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of the best of my known of the best of	Wledge death	occurred at the tim	e date and place	308 S. Coll	ington ave	Rural Route Number, ., Baltimore, MD
	To the Hc within 24 I To the Fu completely	Medical	(Check only 2 Medical Examir one)  29b. Signature and title of certifier	ner: On the basis of examina and manner stated.	tion and/or inve	29c. License	inion, death occurr	ed at the time, date	and place, and du	nth, Day, Year)
	Ŋ		30. Name and address of person who co	mpleted cause of death (Item		rint)		imore, Ma		2004
	Stat Registra		31. Date filed (Month, Day, Year)  MAR 3 0 200	32. Registrar's Signa		house	/	THOTE, M	TATORIO 5	TTSOT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Bonnie Rae Davis April 1, 2004 2050 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1□M 2√2F 212-66-4267 Yrs. Nov. 9, 1954 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Maryland Prince George's 1 ☐ Yes 2/☐ No Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9809 Lemocks Drive 20772 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: spolinite 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Day Care Provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Crumley Lester Berma Jessyner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Davis (Husband) 9809 Lemocks Drive Upper Marlboro, MD 20772 20b. Place of Disposition (Name of 20a. Method of Disposition Apricate6. 20c. Location - City or Town, State Resurrection Cemetery 1 □ Burial 2 □ Cremation 3 □ Removal from State Clinton, Maryland 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Lee Funeral Home MD 20735 proximate rval Between set and Death

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f shoy other traumatic event, the Madical Examiner must be nutilied at

Baltimore, Maryland 21215-0036

Pages 1

permit. Pages Department of Important: If it any injury or o

Completed by Funeral Director

Be

Physician/Medicai Examiner use as the burial-transit Completed by To the Hospius Committies that the Funeral Director: After this certification to the Funeral Director: After this certification to the funeral director. Be Certification: To

25. Was case referred to medical

5 Pending investigation

6 Could not be determined

1 ☐ Yes 2 ☑ No

27. Manner of Death

1 Matural

3 ☐ Suicide

29a. Certifier

Medicai

2 ☐ Accident

4 - Homicide

Hospital:

1 🔲 Inpatient

28a. Date of Injury (Month, Day Year)

this certificate has been

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

21. Signature of Puneral Service L	Icensee	EE. Mario and Address of Lacinty		The street
Det 5.53th	M00542	6633 Old Alexandr:	la Ferry Ro	l Clinton, MD 20
23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused the death. Do not only one cause on each line.	t enter the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	-a. MyDcard	ial Intarction		Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of)  Due to (or as a consequence of)	sim Dependent Diabote	7	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23	8d. Date of delivery Month Day Year
Part II. Other significant condition	ns contributing to death but not resulting in th	ne underlying cause given in Part I.		e contribute to the cause of death?

4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

24a. Was an autopsy performed? 1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23826 Bromch Ave. C 31. Date filed (Month. State Registrar

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

3□ DOA

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

			1 - For State Registrar	State of Marylar		artmen rtificat			d Mental Hy	giene Reg. No. 2	004	1297
	Stat.		Decedent's Name (First, Middle, Last	st)			-		2. Date of D	eath		3. Time of Death
	Physici /Medio		Silvio Jos	seph Daneri					April	1, 200	Year 4	11:00A M
J	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of De	ath	4c. Cour	ty of Death	
		奖	Suburban H				ethes				ontgo	
ŀ	Funeral		5. Social Security Number 6. S	CVM 2DE		Months	1 Year Days	If Under 24 H Hours M	in. (Month, D	ay, Year)	Cou	place (State or Foreign intry)
	Director	ļ	577 34 1011 Usual Residence of Decedent	90	113.				Dec 25	, 1913	Was.	hington DC
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	Many Firsh	tor	Marvland Prince	George's	For	estvi	116					1 ☐ Yes 2 ☐ No
	or 28g	Director	10e. Street and Number	Jedige D	101	10f. Zip				10g. Citizen o	f What Cou	
	within 72 hours after death with the Maryland ene. then "netural", or Items 23e or 28e-1 show ta Medical Exeminar must be notified at		3709 Donne	ll Drive			20	)747		Unit	ed St	ates
	ems erre	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Deced	dent of His	panic Origin? , Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	o- 14. R.	ace - Ameri lack, White	
36	or It	y Fu	1 Never Married 2 Married	1 ☐ Yes 2V No If Yes, Give X		1 ☐ Yes		Specify:	, , , , , , ,	Spec	eifv:	
Ö	hours	d by	3XXWidowed 4 □ Divorced	Year or Dates:							W.	hite
45	I within 72 ho liene. r than *natu Ine Medical	Completed	15. Decedent's Ec (Specify only highest gra		(Give	dent's Usua kind of woi DO NOT us	rk done di	uring most of w	vorking	16b. Kind of	Business/Ir	ndustry
112	withi ene. then	шс	Elementary/Secondary (0-12)	College (1-4or 5+)		eral				Tino	Serv	ino
9	Hyg It had	Be C	17. Father's Name (First, Middle, Last)		Gen	етат			lame (First, Middle			ICE
lan	2 to 5 to 5	To B	Joseph Daneri						Theresa '	Torres		
Maryland 21215-0036	short ama	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailin	ng Address	(Street a		Rural Route Numb		n, State, Zij	p Code)
-	alth a		Deborah Messier	(Daughter)	10	600 R	adsto	ock Cou	rt, Dama	scus, M	D 208	72
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		20a. Method of Disposition		Place of Dispo	sition (Nam	ne of ther place	)	Date	20c. Location	n - City or T	own, State
E	Page nent c int: If		1 <b>X</b> ∯urial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemoval from State		-		·	1 5, 200	4 Suitl	and. i	Maryland
atti	mit. ports y inju		21. Signature of Funeral Service Licen		22	2. Name an	d Address	of Facility L	ee Funer	al Home	Inc (	6633 01d
m	22 = 3		LOQURY -T	tee MO 110								and 20735
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the deal	th. Do not ent	er the mod	e of dying	, such as card	ac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. ASPIRI	ATION		PNE	MOHU	IA			Onset and Death
	/Medical		resulting in death)	Due to (or as a consec			INC	Oct V	17.			
	Examiner		Sequentially list conditions,	6. CONGI		E	CAR	MOM'	MATHY			
	Sit 9d	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):							
	ecute and trans	Examine	that initiated events resulting in death) Last	c	uonaa af):							
60,	be ex cian burial			Due to (b) as a consec	(derice of).							
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dicai	•	d								
9 X	ath certific	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancy					004.5		
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta	al death 3□	Ectopic pro					ate of deliv fonth	ery Day Year
o.	that the de led by the a detached t	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown	102(11 3)	J Other (spi	ociiy)					
<b>Q</b>	requires that the veen signed by th hould be detache		Part II. Other significant conditions c	ontributing to death but not res	sulting in the u	nderlying ca	ause giver	n in Part I.	23e. Did	tobacco use co	ntribute to t	he cause of death?
of Vital Records,	luires rign	d by							1 🗆	Yes 2 No	3 🗆 Prot	bably 4 Dunknown
Ö	w requir been s should	Completed							24a. Was	an 24h	Wara auto	opsy findings available
Re	The law ate has b page 2 st	E C							auto perfe	psy prmed?	prior to co death?	mpletion of cause of
tal		ပိ	25. Was case referred to medical					26 Place of D	1 Yes	2 No	1 🗆 Yes	3(2 No
>	cer	0 0	examiner?	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DO	Other	2000000	Home 5 Res		ther (Specia	64)
0		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		8c. Injury	at		how injury occu		y)
Ö	Attending Fr death. sctor: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	м	Work? 1 □ Y	es 2 No				
Division		ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory	, office		28f. Location ( City or To	Street and Num	ber or Rura	al Route Number,
ō	spitel or A ours after herel Dire filled in by	Cer	A	ballarig, etc. (opeon	<b>9</b> 7				Oily or 10	wii, State)		
	Hospitel	edical	29a. Certifier Certifying Ph	ysician: To the best of my knowing: On the basis of examination	owledge, death	n occurred a	at the time	, date and pla	ce, and due to the	cause(s) and n	nanner as s	stated.
	To the Hos within 24 h To the Fur completely	ledi	one)	and manner stated.					Carred at the thire,			
	Viit To	Σ	29b. Signature and title of certifier	sami M	·D		License			29d. Date sign	ed (Month,	Day, Year)
			P My			1	1-d	7660		4/11	07	
	0.5		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	12 11:1	LE PIL	VIE DE	aculle		
M	14.3		31. Date filed (Month Day Year)	32. Redistrar's Signa		July	EU/U	111	1	Mi) Z	0850	2
	Sta Registr		The same and the s	2004 Sz. Healstrar's Signa	1	10316	1					

			1 - For State Registrar	State of Marylan		artment of tificate o		and Men		ne No. 200	4 12978
	Physicia /Medic Examin	al er	Decedent's Name (First, Middle, Last)     Carl Hampton Dunn     4a. Facility Name (If not institution, give     Country Meadows Re	street and number)			n, or Location of	Man of Death	ch 21,	Day Yea 2004 4c. County of D	10:00 a M
H	Funeral Director		Usual Residence of Decedent  10a. State 10b. County	(M 2□F 87	Yrs. y, Town or Lo	Months Day		Min. Oc	Date of Birth Month, Pay, Ye	1916 V	Birthplace (Stete or Foreign County) Inginia
h with the Man	23a or 28a-f al	Funeral Director	Maryland Frederic  10e. Street and Number  5955 Quinn Orcha		rederio 205	10f. Zip Cod	° 704			Citizen of What	1 □ Yes 2X No Country?
ours after deat	ral, or items?	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑No ff Yes, Give Year or Dates:		Was Decedent of Yes, specify C	No Specify:	gin? (Specify i, Puerto Rica		Black, W	White
iled within 72 h	if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic event, the Medical Experimenment be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)		(Give	dent's Usual Ock kind of work do. DO NOT use rel Employ (	ne during mos ired) ed Decc	rator			ng Contractor
d 2 should be f	5 5 5	To Be	James G. Do  19a. Informant's Name/Relationship (7)  Carl H. Dunn, Jr	rpe, Print)		ng Address (Stre	eet and Numbe	ate Ta	1bot ute Number, C	ity or Town, State	e, <i>Zip Cod</i> e) 20 <b>111</b>
DOLLINGIE, IN	nent c		20a Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Euneral Service Licens	Removaf from State 20b. F	nt Oliv	estion (Name of natory or other )	ry Man	Date ch 25, 2	004 Fr		, Maryland
	्रि स्थ सं		23a. Part 1. Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Final	MOO 255 ications that caused the deat ne/cause on each line.	h. Do not ent	er the mode of	tying, such as	cardiac or res			21701  Approximate fntervaf Between Onset and Death
rebe executed in	nysician Medical xaminer pe pruial-transit	ical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):		is said	52			Years
The law requires that the death certifical	been signed by the attending physicien and should be detached for use as the burial-transit	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. ff yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	fdeath 3[	Ectopic pregna Other (specify				23d. Date of Month	delivery Day Year
Records, T	been signed b	Completed by Ph	Part 11. Other significant conditions co Bladder Co Atrial Fibri	ncer Pa	,	nderlying cause	4 1		1 ☐ Yes 24a. Was an	2 No 3	e to the cause of death?  Probably 4 Munknown  autopsy findings available
VII di	certifica	о Ве Сотр	25. Was case referred to medical	Hospital:	ER/Outpatier	2 2 DOA		of Death (Ch		d? death	′es 2 Mo
DIVISION OF VITA	within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	Certification; T	27. Manner of Death  1   Natural 5   Pending investigation   Pending investiga	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. l	njury at Work? I Yes 2	28d. No	Describe how  Location (Stree	injury occurred	Rural Route Number,
VIO enite or	4 hours after Funeral Dire tely filled in b	Medical Certi	29a. Certifying Phy	building, etc. (Special sician: To the best of my knotiner: On the basis of examinations of the state of the	owledge, deat	h occurred at the	e time, date ar	nd place, and	City or Town, S due to the caus t the time, date	e(s) and manner	as stated. due to the cause(s)
Tothe	To the comple	Mec	29b. Signature and title of certifier  30. Name and address of person who co	and manner stated.	п 23а) (Туре,	D.	ense number			Date signed (M	12004
	Sta Regist	ate rar	31 Date filed (Month, Day, Year) MAR 2 4	2004 M, D,	2/0	Busines	s Cent	er Dr.	Keisi	testou	4 MD21136

			1 - For State Registrar	State of Ma	ryland		artmen tificate					_	200	4 12970
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) Lero	у		Dro	ddy	Ŧ-	Les des	ı	Date of Dea Month March	12		04 1:30 A <sup>M</sup>
	Funeral		4a. Facility Name (If not institution, give s  Frederick Memor  5. Social Security Number  437-34-4620  6. Sex	ial Hosp		. 1 ast birthday) Yrs.	_	ede	rick If Under	24 Hrs. 8.	Date of Birt (Month, Day	h v. Year)	1 C	rick rthplace (State or Foreign Jountry)
	Director show		Usual Residence of Decedent  10a. State Maryland Tob. County Frederic			, Town or Lo	cation			Au	igust	19,19	28 Lo	ouisiana  10d. Inside City Limits  12∑Yes 2□No
	ath with the P 23a or 28a- ust be notifi	rai Director	10e. Street and Number 2508 Coach House Wa				10f. Zip	2170				U.	n of What C	
9036	72 hours after death with the Maryland naturel', or items 23a or 28a-f show disal Examiner roust be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:			Vas Deced fYes, spec I□Yes 2			gin? (Specif n, Puerto Ric	y Yes or No- an, etc.)		Black, Whi	erican Indian, ite, etc. erican Indiar
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified as	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)			16a. Deced (Give life. L Facili	kind of wor OO NOT us	k done d e retired)	uring mosi	t of working			of Business	Vernment
Maryland	2 should be filed and Mental Hyg le marked other aumatic event,	To Be C	17. Father's Name (First, Middle, Last)  Pinkney Droddy  19a. Informant's Name/Relationship (Ty)	na Printl		19h Mailin	a Address	(Street a	Pear	1 Doy	irst, Middle, Le oute Numbe			Zin Coda)
ore, Ma	ges 1 and 2 s of Health an : If item 27 let or other trau		Edelgard Droddy - V  20a. Method of Disposition  1 △ Burial 2 □ Cremation 3 □ R	Vife	20b. Pl	2508 ace of Dispo- metery, creating in the con-	Coach	n Hou	ıse W	ay, Fi	rederi	ck, M	laryia	nd 21702
Baltimore,	permit. Pages Department of I Importent: If it eny injury or o	9 X	*4 Donation 5 Other (Specify)  21. Signature of Funeral Service bicense			rans (	Cemete . Name and	ery d Addres	Ma s of Facilit	y Stau	iffer	Funer	al Hor	lls, Maryland me ryland 21702
8760,	be attending physician and for use as the burial-transit	edicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	e. Sta consequ sto- consequ	tence of):  - Nervience of):					spiratory an	rest,		Approximate Interval Between Onset and Death
P.O. Box 6	death certi e attending id for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 ☐ Fetal	death 3	Ectopic pre					230	d. Date of de Month	livery Day Year
	The law requires that the de ate has been signed by the a page 2 should be detached f	by	Part II. Other significant conditions con	tributing to death bu			iderlying ca	use give	n in Part I.					o the cause of death?
ital Rec		e Completed	25. Was case referred to medical	<i>U</i>					26. Place	of Death C	24a. Was a autop: perfor 1 Yes	med? 2 No		utopsy findings available completion of cause of
Division of Vital Records,	iing Phys 1. After this funeral di	ation: To B	examiner?  1  Yes 2 No H  27. Manner of Death 1 Accident 5 Pending investigation	ospital: 1 Inpatier 28a. Date of Injun (Month, Day		ER/Outpatient 28b. Time of Injury		Bc. Injury Work	<sup>C</sup> 4 □ Nu	rsing Home 28d	5 Resid	ence 6		cify)
Divis	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the 1	i Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Inju- building, etc.	(Specify)	)					City or Tow	n, State)		urai Route Number,
	To the Hospitel within 24 hours a To the Funerel completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Phys	ner: On the basis of and manner stat	examınatı	viedge, death ion and/or inv	estigation,	in my op	nion, deat	d place, and th occurred a	it the time, d	late and pla	ace, and due	e to the cause(s)
)	T wit		29b. Signature and title of certifier	m).			D	CO5	1636			1	12/04	h, Day, Year)
_	10	723	30. Name and address of person who co	M.D., 700	Mont	clair		nue,	Fred	erick	, Mary	land	2170	1
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6 20	32. Rejistra	r's Signati	ure	South.	9					*	

		) cares	1 - For State Registrar	State of Marylan	d / Depa		lealth and	Mental Hy	giene	004 1298
for	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last)     Anna Catherine D     4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Dea	2. Date of De Month March th	Day 2	Year 3. Time of Death 2004 8 • 30 P
	Funeral Director		Moran Manor Nursing 5. Social Security Number 6. Sex 217-28-8898  Usual Residence of Decedent	Home 7. Age (In yrs. 90	last birthday) Yrs.	Western It Under 1 Year Months Days	If Under 24 Hrs Hours Min			Gany 9. Birthplace (State or Foreigr Country) - Maryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Department of Heatih and Mental Hygiene. Department of Heatin 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examinar must be notified at once.	Director	10a. State 10b. County  Maryland Allegany  10e. Street and Number	La	y,Town or Lo	10f. Zip Code			10g. Citizen of	10d. Inside City Limits 1 □ Yes 2 🖫 No What Country?
000	ours after death rai', or Items 23 Exeminer med	by Funeral	562 National Highwa  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	IY  12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		21502 Was Decedent of H f Yes, specify Cuba		Specify Yes or No to Rican, etc.)	USA 14. Ra Bla Specia	ce - American Indian, ack, White, etc. fy: White
Maryiand z 1 z 15-0030	filed within 72 ho Hygiene. ther then "natur int, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)  12  17. Father's Name (First, Middle, Last)		(Give life. i	dent's Usual Occup kind of work done DO NOT use retired Assista	during most of wo	nrking me (First, Middle,	Dent	
Mai yiain	nd 2 should be aith and Mental   27 is marked o r traumatic eve	-	Wilbur Durst  19a. Informant's Name/Relationship (Type Janice M. Durst/nie			ng Address (Street	Nellie and Number or R	Hetz ural Route Numbe	or, City or Town	, State, Zip Code)
allinore,	permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.		20a. Method of Disposition  1 ▼ Burial 2 □ Cremation 3 □ Ri  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	emoval from State  Mt.	Place of Dispo emetery, cren Zion (	sition (Name of natory or other place Cemetery Name and Addres	3/9/	Date /04	20c. Location	- City or Town, State
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, on heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. . <u>Endst</u> a	Gr. Do not ent	ewman Fune antsville er the mode of dyin Cardio	g, such as cardia	1536 c or respiratory ar	rest,	Approximate Interval Between Onset and Death  Grant S
,00,	Pe executed was and will be burial-transit and and and and and and and and and and	lical Examiner	Sequentially list conditions, Tany leading 15 immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uerce of):					
	The law requires that the death centifical tite has been signed by the attending phoage 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year
0. 1 (55 100011	w requires that been signed by should be deta	eted by Ph	Part II. Other significant conditions con	tributing to death but not resu			en in Part I.	1 🗆 Y	es 2□No	
		Be Compl	25. Was case referred to medical examiner?				26. Place of De	24a. Was autop perfor 1 To Yes	med?	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
	ling Ph	은	1 Yes 2 No H	ospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Input 2	ER/Outpatien 28b. Time of Injury	28c. Injury Work	at at	dome 5 Resid		
	spital or Atteno	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At ho building, etc. (Specify ician: To the best of my known	′)		e date and place	City or Tow	n, State)	per or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	(Check only one)  2() Medical Examination  29b. Signature and title of certifier	er: On the basis of examinat and manner stated.	tion and/or inv	29c. License	oinion, death occu	urred at the time, o	late and place,	anner as stated. and due to the cause(s)  Id (Month, Day, Year)
	Sta Registr		30. Name and address of person who cor		za, Fr	Print)		32	7/01	auc T

			1 - State Registrer Cert	rtment of Health and Menta tificate of Death	al Hygiene  Reg. No. 2001 1298
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last)  Theodore E. Donovan	Ma Ma	te of Death Day Year 3. Time of Death onth Day 2004 1301 M
	Examir Funeral Director	ier	Dorchester General Hospital  5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)		4c. County of Death  Dorchester  te of Birth onth, Day, Year)  5/29/23  9. Birthplace (State or Foreign Country)  Maryland
	ne Maryland 8a-f show pulled at	ector	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local  MD Caroline	Federalsburg	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Madigal Examinative must be notified at ances.	by Funeral Director	1 Never Married 2 Married 1 Tyes 2 No	as Decedent of Hispanic Origin? (Specify Ye Yes, specify Cuban, Mexican, Puerto Rican,   □ Yes 2 no Specify:	10g. Citizen of What Country?  United States  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	əd within 72 hou rgiene. Jerthan "natura t, the Medicul E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Moldin	nn's Usual Occupation ind of work done during most of working O NOT use retired) ng Technician	Plastics Mfg.
aryland	should be file nd Mental Hy s marked oth umatic event	To Be		18. Mother's Name (First, Lucy A. W	
o,	iit. Pages 1 and 2 artment of Health a priant: If item 27 is injury or other tree 2.		Dorothy P. Donovan/Spouse 5610  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State Cemetery, crematerly and Donation 5 Other (Specify)  1 Donation 5 Other (Specify)	O Smithville Rd., tion (Name of tory or other place)  Cemetery 3/31/04	Federalsburg, MD21632  20c. Location - City or Town, State  Federalsburg, MD
m	Deparit. Departr Importa		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	16 N. Main St., Fede the mode of dying, such as cardiac or respir	ratory arrest, Approximate Interval Between Onset and Death
	Medical  was pe executed  was provided and  was	dical Examiner	resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	riA elitus	YEARS YEARS
.O. Box 6	at the death certific by the attending p tached for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 C	ctopic pregnancy )ther (specify)	23d. Date of delivery  Month Day Year
Records, P	v requires that been signed should be de	Completed by Pf	Part II. Other significant conditions contributing to death but not resulting in the under Coronal y Altery Discase  Colon	Atrial	e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Ahknown  a. Was an 24b. Were autopsy findings available
Vital H	icien: The certificate harector, page	To Be Comp	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Appatient 2 ER/Outpatient	26. Place of Death (Check	autopsy performed? performed? death?  Yes 2 No 1 Yes 2 No
_	ffer fer ing	Certification; T	27. Manner of eath  1 Ratural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28b. Place of Injury - At home, farm, street building, etc. (Specify)	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No  t, factory, office 28f. Loca	ation (Street and Number or Rural Route Number, or Town, State)
2	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medicai Ce	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death or control one)  Certifying Physicien: To the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of my knowledge, death or control one of the best of the be	ccurred at the time, date and place, and due stigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. a time, date and place, and due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier  ON C. On D. O.	29c. License number	29d. Date signed (Month, Day, Year)
	Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Pril Louis A. NARL P.O. 8.4 7  31. Date filed (Month, Day, Year)  32. Registrar's Signature		ridge MD 21613

DHMH 16 Rev 6/95

Registrar

ORIGINAL

		•	For State Registrar	State of Maryland / Depa	artment of Hertificate of E			ne 10.2004	12983
	Physicia	_	Decedent's Name (First, Middle, Last)     Kermit Lewin DeBoar	rd			Date of Death	Day Year	3. Time of Death 02:00 AM
	/Medic Examin		4a. Facility Name (If not institution, give stre 45 Wells Camp Road		4b. City, Town, or North Ea	st		4c. County of Death Cecil	
	Funeral Director		5. Social Security Number 6. Sex 221 20 0783 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthday) 7. 72 Yrs.	If Under 1 Year Months Days	Hours Min. Fe	Date of Birth (Month, Day, Yea bruary 8	9. Birth Cor ,1932 Car	nplace (State or Foreign untry) North rolina
	the Maryland 28a-f show	ector	10a. State 10b. County  Maryland Cecil  10e. Street and Number	10c. City, Town or Lo			10a. G	Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 🕅 No
36	perrilt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dep urment of Heatile and Mental Hygiene.  Dep urment of Heatile and Mental Hygiene.  The Modicatest if time 27 is marked other than "natural", or items 23a or 28a-f show mary injury or other traumatic event, the Modical Examiner must be notified at Appet.  Apple.	by Funeral Director	45 Wells Camp Road	1 DXYes 2 □ No	21901	spanic Origin? (Specify, , Mexican, Puerto Rica Specify:	Uni	ted State  14. Race - Amer Black, White  Specify: White	2S ncan Indian, o, etc.
Maryland 21215-0036	I within 72 hour iene. r than "natural ihe Wedical Ex	Completed	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12)	tion 16a Decer		tion uring most of working		Kind of Business/l	ndustry
yland	ould be filed Mental Hyg arked other atic event.	To Be C	17. Father's Name (First, Middle, Last)  Eugene J. DeBoard			18. Mother's Name (Fi	graves		
e, Mar	1 and 2 sho lealth and sm 27 is m ther traum		19a. Informant's Name/Relationship (Type Margaret DeBoard/Sp  20a. Method of Disposition	pouse 45 We	11s Camp 1	nd Number or Rural Road, North	h East,		21901
Baltimore,	perrit. Pages Dep rtment of It Importent: If ite any injury or of		1 ∑ Burial 2 □ Cremation 3 □ Ren '4 □ Donation 5 □ Other (Specify)  21. Signature □ Fineral ■ Tyle Lice — e	Rosebank (22	Cemetery 2. Name and Address	2004	2, 4 <u>Cal</u> ch Funer	vert Mary al Home	
	Pnysician /Medical		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.		BCADDE		e	Approximate Interval Between Onset and Death
760,	cate be executed the control of the	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):	ncmq.	BCADDER			6 med/ts
.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23c  23b: Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)			23d. Date of deli- Month	very Day Year
<u>α</u>	quires that t in signed by uld be deta	þ	Part II. Other significant conditions contr	ibuting to death but not resulting in the u	inderlying cause give	on in Part I.			the cause of death?
Vital Records,		Completed					24a. Was an autopsy performed 1 Yes 2 1	prior to c death?	topsy findings available completion of cause of
	ding Physician:  A. After this certific funeral director,	To Be	27. Manner of Death  1 Natural 5 Pending	spital: 1 Inpatient 2 ER/Outpatier  28a. Date of Injury (Month, Day Year)  28b. Time o	of 28c. Injury Work	4   Nuising Home		6 □Other (Specially)	rify)
Division of	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f.	Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	edical	(Check only 2 Medical Examine one)	cian: To the best of my knowledge, deat er: On the basis of examination and/or in and manner stated.	vestigation, in my op	pinion, death occurred	at the time, date a	and place, and due	to the cause(s)
	With	×	29b. Signature and title of certifier	my Mit	29c. License	1858P	n) 29d. [	Date signed (Month	04 1. (Jay, 1 ear)
	5+1		30. Name and address of person who com	n IT Sex	Print)	no			/
	Sta Regist		31. Date filed (Month, Day, Year)  APR 1 2004	32. Aegistrar's Signature	de				

	1	= For State Registrer	of Maryland / Depa	rtment of Hea tificate of De			ene 2004	12984
Physicia /Medica	_	1. Decedent's Name <i>(First, Middle, Last)</i> Barbara Jane E	tchison			2. Date of Death April 8	3, Day 2004 Year	3. Time of Death 5:30 A M
Examine Funeral Director	er	4a. Facility Name (If not institution, give street and 707 Pioneer Trail  5. Social Security Number  220–38–2673  6. Sex	7. Age (In yrs. last birthday)		Under 24 Hrs.	8. Date of Birth (Month, Day, ) Dct.11.1	4c. County of Death  Calve  (ear)  9. Birth Cot OA2  Wash	
'e, Maryland 21213-UU30  1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28e-1 show other treumatic event, the Migical Examiner must be multiple at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MD  Calvert Co.  10e. Street and Number  707 Pioneer Trail  11. Marital Status  1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade complet)	Forces?	10f. Zip Code  20657  Nas Decedent of Hispar f Yes, specify Cuban, M  I Yes 2 X No Sk  dent's Usual Occupation kind of work done durin DO NOT use retired)  rk  18.  19.  19.  19.  19.  19.  19.  19.	g most of workin  Mother's Name  Emma J.  Number or Rural  il, Lusi  Aprif  ery 200	(First, Middle, Mary Mary Mary 13, 04	Retail Staden Sumame)  City or Town, State, Zand 20657  Oc. Location - City or 18  Grentwood,	ican Indian, , etc. ite industry  Ore ip Code) own, State Maryland
Baltimol permit. Pages Department of Importent: If II eny Injury or o		21. Signature of The rvice Licensee,	8:	Name and Address of 125 Souther	FacilityLee l n Maryl:	Funeral and Blvd	Home Calve L., Owings,	ert, P.A.
B760, cate be executed /Medical Examiner the burial-transit	dical Examiner	Eacquantially lest our cultions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events c.	to (or as a consequence of):  Toba  to (or as a consequence of):  to (or as a consequence of):			Toophatory and		interval Between Onset and Death, (2 mouth)
COrds, P.O. Box 6  w requires that the death certific been signed by the attending I should be detached for use as	Completed by Physician/Medi	in the past 12 months?	regnant at time of death 5 C nknown to death but not resulting in the u	Dectopic pregnancy Other (specify)  nderlying cause given in	n Part I.	1 Yes	24b. Were au	Day Year
Division of Vital Records,  To the Hospitel or Attending Physicien: The law requires the within 24 hours after death.  To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be death.	Medical Certification; To Be Com	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  28a. F  5 Pending investigation 6 Could not be determined  28e. F  28a. Certifier (Check only 2 Medical Examiner: On the	I Inpatient 2 ER/Outpatient ate of Injury 28b. Time of Injury Month, Day Year)  Place of Injury - At home, farm, struiding, etc. (Specify)  The best of my knowledge, death the basis of examination and/or inmanner stated.	ont 3 DOA Other:  ### 28c. Injury at Work?  ### M 1 Yes  ### Yeet, factory, office  ### Accounted at the time, covertigation, in my opinion  ### 29c. License nu	4 Nursing Hom 2 2 No 2 date and place, a	perform 1 Yes 2  Check on one ne 5 Resider 8d. Describe how  8f. Location (Stre City or Town, and due to the cau and at the time, dai  29	ed? death?  1 Yes  ce 6 Other (Specy injury occurred  set and Number or Ru State)	2 □ No  ify)  ral Route Number,  stated. to the cause(s)
//O Sta Registr		30. Name and address of person who completed Stephen P. Cafferty  31. Date filed (Month, Day, Year)  APR 0 9 200		Print) Dares Beac			rederick,	MD 20678

	1	For State Registrar	State of Marylan		artment of Hertificate of L			iene 19. No. 2004	12985
	_	Decedent's Name (First, Middle, Last)					2. Date of Death Month	h Day Year	3. Time of Death
Physici /Medio		Mary Virginia Edma	nson				April	2 2004	0715 <sup>M</sup>
Examin	_	4a. Facility Name (If not institution, give s			4b. City, Town, or			4c. County of Death	
		Calvert Manor Heal			Rising Su	In If Under 24 Hrs.	8. Date of Birth	Cecil	place (State or Foreign
Funeral Director		5. Social Security Number 6. Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. 95	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, June 23	Year) Cou	olace (State of Poleign office) yland
p .		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty. Town or Lo	ecation				10d. Inside City Limits
aryia shov	5								1 ☐ Yes 2 🛣 No
the M	Director	Maryland Cecil  10e. Street and Number	Nort	h East	10f. Zip Code		10	Og. Citizen of What Cou	ntry?
with		31 Falls Road			21901		U	nited State	es
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Hygiene, than "natural", or Items 23s or 28s-1 show ant, the Maylest Examination at the nutified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1		Was Decedent of Hill If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: WI	
Maryland 21215-0036 d2 should be filed within 72 hours aft in and Mental Hygiene. Tris marked other than "natural", or traumatic event, the Mayloal Examil	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occupa	luring most of work		16b. Kind of Business/Ir	ndustry
Ind 21215-0 be filed within 72 ho tal Hygiene. d other than "naturevent, the Mayloat	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,	)			
d 212 filed withi Hygiene. other than		12 17. Father's Name (First, Middle, Last)		Seams	stress	18. Mother's Nam	e (First, Middle, M	Manufactur: Maiden Surname)	ıng
E a a a a a a	o Be	John Starett Russe	11			Anna Kli	ne		
re, Maryla s 1 and 2 should f Health and Men Item 27 is marke other traumatic	2	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street a	and Number or Rui	al Route Number,	City or Town, State, Zip	Code)
re, Ma 1 and 2: Health at tem 27 is		Carolyn M. Kirk/Da	ughter	11 Sc	hool Hous	se Lane,N	orth Eas	t,Maryland	21901
Baltimore, permit. Pages 1 an Department of Heat Important: If then 2 any injury or other once.		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ F 1 4 □ Donation 5 □ Other (Specify)	Removal from State NO	cometery cre th Eas Cemet		st April	6, 04 N	20c. Location - City or Torth East, N	
Balti permit. Departri Imports any inju		21. Signature of Fu rai Service Lices	99					eral HOme h East,Mary	1and 21901
		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the dea	th. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Sen Co	Deux	ha.				Onset and Death
/Medical		resulting in death)	Due to (or as a consec	quence of):	1 10 64				
Examiner		Sequentially list conditions,	. Anthre	~					
) ₽ = ==	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a consec	quence ory					
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(a) A cate be executed physician and the burial-transit	dicalE		d						
687 tiflicate I ig physi as the b	led								
I Records, P.O. Box 68760, The law requires that the death certificate be executed tale has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1□Live birth 2□Fet 4□Pregnant at time of o 9□Unknown	al death 3 [	⊒Ectopic pregnancy ⊒ Other (specify)			23d. Date of deliv Month	ery Day Year
ds, P.	d by Ph	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the t	inderlying cause give	en in Part I.	23e. Did tob 1 □ Ye	pacco use contribute to t es 2 No 3 ☐ Pro	the cause of death?
Division of Vital Records, tor Attending Physician: The law requires to after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	plete						24a. Was ar autopsy	n 24b. Were auto y prior to co	opsy findings available ompletion of cause of
The The	5						perform 1 □ Yes 2	No 1 Yes	2□ No
/ita	Be	25. Was case referred to medical examiner?	Hospital:		Otho		th (Chack only one		
Of Physical this can direct and direct this can direct this ca	2	1 ☐ Yes 2 ⚠ No  27. Manner of Death	28a. Date of Injury	ER/Outpatie	nt 3 DOA	4 Nursing H		nce 6 □Other (Speci ow injury occurred	fy)
Offing ding After funer	ton	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work	<br Yes 2 □ No			
Atten deat deat ctor:	flca	3 Suicide 6 Could not be	28e. Place of Injury - At I	nome, farm, st	reet, factory, office		28f. Location (Str. City or Town	reet and Number or Rur	al Route Number,
Div	Certification:	4  Homicide	building, etc. (Spec	iry)			City of Town	i, Siaie)	
Division of Vital Records, F To the Hospital or Attending Physician: The law requires tha within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	Medical C	29a. Certifier 1 💢 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, dea ation and/or in	th occurred at the tin nvestigation, in my o	ne, date and place, pinion, death occur	, and due to the ca rred at the time, da	ause(s) and manner as s ate and place, and due t	stated. o the cause(s)
To the Fo the somple	₹ F	29b. Signature and title of certifier			29c. License		29	9d. Date signed (Month,	Day, Year)
- >= 0		I fini cle i Ho	MD		D04	823		4/6/04	
i -		30. Name and address of person who c			Print)	Ellera	viel 2	1921	
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign						
Regist		APR 0 6 21	004	de p	Joseph .				

		4	Please		aryland / De		Health and M	lental Hyg	2001	. 12000
_			Registrar			ertificate of	Death	2. Date of Dea	Fag (J )_2	3. Time of Death
	Physicia /Medic		1. Decedent's Name (First, Middle, La Lois Pau		r			Month APRI	L 2 2004	4:30A <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, giv	re street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	
			5. Social Security Number 6. S		CAL CENT ge (In yrs. last birthda		PLATA  If Under 24 Hrs.	8. Date of Birth	CHARI	ES
2	Funeral Director		579-09-0283	1 M 2 K	85 Yrs.	Months Days	Hours Min Ma	rch 12	,1919	thplace (State or Foreign puntry) PA
2,	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
Y	e Maryli Ba-f eho	ctor	MD Char	les	La Pl					1X Yes 2 □ No
3	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Ie marked other then "natural", or Itama 23e or 28e-f ehow eumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 104 Wesley	Drive		10f. Zip Code 206	46		USA	ountry?
35	or dea	uner	11. Marital Status	12. Was Decedent Armed Forces		<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	Hispanic Origin? (Spe pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
036	urs afte	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2√7 If Yes, Give X Year or Dates:	No	1□Yes 2□XNo	Specify:		Specify:	White
21215-0036	72 ho	Completed	15. Decedent's E	ducation ade completed)	16a. De	cedent's Usual Occu ve kind of work done	pation during most of worki	ing	16b. Kind of Business	/Industry
7	d within 72 ho piene. r then "natu	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	o. <i>DO NOT</i> use retire lerk	od)		m: +1 - 0	
2	led w lygier her ti		17. Father's Name (First, Middle, Last	P1		IEIK	18. Mother's Name	/First Middle	Title C	olipany
Maryland	d be filed ntal Hyg ed othe	Be c	Charles J. Par				Wilma E			
الم	t and 2 should Health and Men tem 27 le marke other treumatic	2	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Street	t and Number or Rura	al Route Number	r, City or Town, State,	Zip Code)
2	7.2 € d		Carole Stone/Da	aughter	45	958 Clar	ks Rd. C	alifor	nia,MD 2	0619
ē,	s 1 and 2 of Health Item 27 I		20a. Method of Disposition	35 1/ 3	20b. Place of Dis	position (Name of rematory or other pla	ice)	Date	20c. Location - City or	
E C	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	(v)	Cedar	Hill Ce	metery 4	/7/04	Suitlan	d,Maryland
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot		21. Signature of Funeral Service Lice	chul MO	945				AL HOME, TA,MD 20	
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	Physician		Immediate Cause (Final disease or condition	lint	zola led	inal B	loodin	9.		Onset and Death
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687	ificate g phys	edic		d						
Box 687	leath certificate to attending physical of a tending physical of a tending physical of the tending the tending tending the tending ten	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 □Ectopic pregnanc	27		23d. Date of de	
B	that the death ed by the atte detached for	Physician/Medic	in the past 12-months? 1 □ Yes 24 No 9 □ Unknown			5 Other (specify)	.,		Month	Day Year
P.O.	that the		Part II. Other significant conditions	contributing to death	out not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
ds,	w requires that s been signed t should be det	d by	Aspiration f	Numm	orua k	espira	ipry	1 □ Y	es 2□No 3□P	robably 4 Unknown
co	w req	lete	Jailine D	cherce	htis	1	,	24a. Was a	an 24b. Were a	utopsy findings available
Re	he law e has age 2 :	Completed	70010011	our Cross				autops perfori	med?   death?	completion of cause of 2 □ No
tal	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Death			
<u>&gt;</u>	ysici	To B	examiner?	Hospital: 1  Inpat	ent ZER/Outpat	tient 3□ DOA Ot	her: 4 Nursing Ho	me 5 🗆 Reside	ence 6 □Other (Spe	ecify)
0	ng Ph fter th neral		27. Magner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inj (Month, D.	ury 28b. Time ay Year) Injur	y Wo		28d. Describe h	ow injury occurred	
Sio	eath. or: A	catle	2 Accident investigation 3 Suicide 6 Could not to	he -			Yes 2□No	00/ 1 / / 0		10 1 1 -1 -1
Division of Vital Records,	el or Att	Certification:	4 Homicide determined	200. Place Ut II	ijury - At home, farm, tc. <i>(Specify)</i>	street, factory, office		City or Tow	treet and Number or R n, State)	urai Houle Number,
	To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical C			of examination and/or				ause(s) and manner a late and place, and du	
V	ro the vethin on the comple	Med	29b. Signature and title of certifier	012		29c. Licen	se number	2	29d. Date signed (Mon	th, Day, Year)
	F > F 0		▶ Most	latta		7	10507		4-2-0	$\forall$
			30. Name and address of person who	completed cause of	death (Item 23a) (Typ		12587			LDORF, MD
M	P 10		GIRJA S. RAT		NA MDICA	L CENTER	7C POST	OFFIC	E RD.	20602
	Sta Regist		31. Date filed (Month, APR of E	2004 Reg	rar's Signature	Brack ,				

			For	State of M		•	ırtme	nt of H	lealth :	and M			ne 200	7/ 10	
		_	l = State Registrar			Cer	tifica	te of l	Death	1		Reg	No. ZUL	14 16	987
	Physicia	an .	Decedent's Name (First, Middle, La								2. Date of	1	Day Ye	ear	of Death
	/Medic	al .	Gertrude Marie F				4h Cin	Town or	r Location		larch	20,	2004 4c. County of (	6:45	5 P M
	Examin	er	4a. Facility Name (If not institution, give 2721 Vista Court		,			1dorf		OI Dealli		\$	Charle		
	Funeral		5. Social Security Number 6. S	Sex , 7. A	ge (In yrs. I	ast birthday)	If Und	er 1 Year	If Under	24 Hrs.	8. Date of	of Birth	9.	Birthplece (State Country)	or Foreign
и	Director		145-14-8908	I□M 20ÅF	90	Yrs.	Months	Days	Hours	Min.	July	of Birth h, Day, Yo	1913 N	ew Jerse	<u>.</u> y
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	City Limits
	lanyla shov	٥	Maryland Charles		1.00,011	Wald									es XX No
	28a-1	rect	10e. Street and Number		.l	Wala		ip Code				10g	. Citizen of Wha	at Country?	
	within 72 hours after death with the Maryland ene. then "natural", or items 28a or 28a-f show then Madical Exeminer is and be mailled at	Funeral Directo	2721 Vista Court					206	503				USA		
	death	ner	11. Marital Status	12. Was Decedent Armed Forces		S. 13. \	Was Dec	edent of H	ispanic Or an, Mexica	rigin? (Spe n, Puerto l	cify Yes o	or No-		American Indian, White, etc.	
98	or the	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣				2 <b>X</b> No	Specify				Specify:	White	
Ö	hours turel',	ed by	3 Widowed 4 □ Divorced  15. Decedent's E	Year or Dates:		16a, Deced	lent's Us	ual Occup	ation			16	b. Kind of Busin		
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yla	should be and Mental marked o	2	William Thomas B			1		(2)					pearing	7: 0-4-1	
Maryland 21215-0036			19a. Informant's Name/Relationship		<b>+</b> 0 10								ity or Town, Sta	ite, <i>Zip Cod</i> e)	
	permit. Pages 1 and 2 Depertment of Health a Important: If them 27 li any injury or othar tra ance.		Marie K. Cianciol 20a. Method of Disposition	o - Daugh	20b. P	2721 Place of Dispo	sition (N	ame of			ate		0603 c. Location - Cit	ty or Town, State	
Baltimore,	ages ant of it: If it y or o		1 Bunal 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Speci		3	<sub>emetery, crer</sub> ington				4-2-0	14	Δr	lington	, Virgin	ia
ij	ortan injur		21. Signature of Funeral Service Lice			22	Name	and Addres	ss of Facil	itv	, ,	<u> </u>	i ing con	, VIIGIII	Ια
ä	permit. Depertimon import any injury		> Jakorthyth			. P	Ω	B∩x	ral   156	Wald	lorf.	MD	20604		
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2	Physician		Immediate Cause (Final disease or condition	a AL	21	~ Fi	~	ER	2'-	0	5	20	8	Offiset an	u Death
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K 68	leath certificate b attending physical for use as the b	Med	IF FEMALE:	23c. If yes, outcom	o of process	1001							224 5-4-	A dallara	
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Feta	Ideath 3	Ectopic Other (	pregnancy	1				23d. Date o Month		Year
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rds	equire en sig suld b	ed b										1 Tes	2 No 3[	Probably 4 [	Unknown
900	a so	Completed									24a.	Was an autopsy	ong	re autopsy finding or to completion of	s available cause of
E E	Thate ate	Com									101	performe Yes 2	d?d dea 1□	th?  Yes 2□ No	
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	00	e of Death		_			
of \	S S	٠ <u>۲</u>	1 Yes 2 No	1 ☐ Inpat		ER/Outpatier 28b. Time o		28c. Injur	4 🗆 1			•	e 6 Other (	(Specify)	
on	fing After fune	tlon	1 Natural 5 Pending 2 ccident investigation	(Month, D	ay Year)	Injury	М.	Wor	k?`  Yes 2.⊑				,,		
Division of Vital Records,	pitel or Attending ours after death. lerel Director: Aftel filled in by the fune	Certification:	3 Suicide 6 Could not	28e. Place of I	njury - At h	ome, farm, sti	reet, fact	ory, office				tion (Street		or Rural Route No	ımber,
Ö	s after of Dire	Serti	4 Homicide	building, e	etc." (Specif	γ)					City	or rown, .	olale)		
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	To the Hos within 24 h To the Fur completely	Medi	one) 29b. Signature and title of certifier	and manner s	stated.		2	9c. Licens	e number			29d	Date signed (I	Month, Dey, Year	)
	To To		1/Cine	MACL	ti-			Ca	£3	5			3-1	9-04	
<b>.</b>			30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type.	Psint)		-	ر ٠٠				'	
1	84		Po Be	+ 17	23		PL	fc	1	nd		20	646		
	St: Regist	ate	31. Date filed (Month, Day, Year) MAR 3 0	2004 32. Rolls	trar's Signa	ature	and the								

			Please I  State Registrer	State of Marylan	d / Depa		lealth and Mer	ntal Hygier	_	12000
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) $Ear1$	0. Fo	ote		A	Date of Death Month  Dril 9,	2004	3. Time of Death 1:45 A M
	Examin		4a. Facility Name (If not institution, give s 11880 Coster			4b. City, Town, o	r Location of Death $by$	4	c. County of Deat Cal	
	Funeral Director		212-30-2944	7. Age (In yrs. 65		If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min. A	Date of Birth (Month, Day, Yea Ug.1,19	9. Birt 938 Mar	hplace (State or Foreign untry) y $1$ a $n$ $d$
	Aaryland f show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Calv		y, Town or Lo	usby				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the Marylan 3s or 28a-f show	i Direct	10e. Street and Number 11880 Coster			10f. Zip Code	657	10g. (	Citizen of What Co	untry?
920	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hyglene. ortent: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show injury or other traumatic event. The Medical Examination to collificate.	Completed by Funeral Director	11. Marital Status  1 X Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes ② No	dispanic Origin? (Specify an, Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - Ame Black, Whit Specify: B	e, etc.
21215-0036	n 72 ho "natur edical	ieted	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of working d)	16b.	Kind of Business	Industry
212	d within giene. ar than "	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	1	Laborer			Constru	ction
Maryland	nould be filed within the Mental Hygiene. Nerked other then natic event, the M	To Be (	17. Father's Name (First, Middle, Last) Burton	Foote			18. Mother's Name (F Viola		Gross	
, Mar	and 2 sho salth and n 27 is my ser traums		Viola Foote/Mo	ther	118	80 Cost	er Road	Lust	y, MD	20657
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If itam 27 It any injury or other tra once.		20a. Method of Disposition  1	1 /	• Joh	osition (Name of matory or other pla nUMC Ce	m. 4/15/	04 Lu	Location - City or ISby, M	)
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68760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.  Due to (or as a consequence)						
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/ital	eician: The la certificate ha irector, page 3	Be C	25. Was case referred to medical examiner?	Hospital:			26. Place of Death (C	1		
on of	ing Phye	ion: To	27. Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju	4   Ruising Home	5 esidence l. Describe how in	6 □Other (Spe	cify)
Division	tance eath tor:	Certification:	2 Accident 3 Suicide 4 Homicide  1 Homicide	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st			Location (Street City or Town, St.		ural Route Number,
	To the Hospital or At within 24 hours after d To the Funaral Diract completely filled in by	Medical C		rsician: To the best of my known iner: On the basis of examination and manner stated.						
	To the within To the compl	Me	29b. Signature and title of certifier	Flind Bl	upi-	29c. Licen	19427	29d. (	Date signed (Mont	h, Day, Year)
	5		30. Name and address of person who c		m 23a) (Type	, Print)	Princ	e Frede	rick. N	ID 20678
		ate	31. Date filed (Month, Day, Year)	32. Registra s Sign	ature &	South	9		, 1	

DHMH 17 Rev 1/2001

EARL O. FOOTE

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			For State	State of Mar		rtificate of l			211111.	12989
			Registrar  1. Decedent's Name (First, Middle, La	et)	00	inicate of t	Jean	2. Date of Deat	g. 110.	3. Time of Death
	Physici	an						Month	Day Year	M
F	/Medic		Kathryn 4a. Facility Name (If not institution, giv	Campbell	Fre	ederick	Location of Death	April	1 2004 4c. County of Death	3:20 p **
1	Examin	er					Frederic	l~	Calve	
	Funeral		Calvert Memorial 5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
	Director		572-09-8655	□M 2XF 88	Yrs.	Months Days	Hours Min.	July 13	1915 Min	nesota
	D .		Usual Residence of Decedent  10a. State 10b. County		Oc. City, Town or Lo	posting				10d. Inside City Limits
	aryla shov	5			_					1 ☐ Yes 2 ☑ No
	he M 18a-f	ecto	Maryland   Calvert		Solomons	10f. Zip Code		110	ng. Citizen of What Cou	
	with t	Funeral Director	11740 Asbury Circ	10 Ap+ 11	216	20688	2	"	U.S.A.	antiy :
	ns 23	era	11. Marital Status	12. Was Decedent Ev				ocify Yes or No-	14. Race - Amer	ican Indian,
"	Iter d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	Black, White	
93	urs a al', o	b	3   Widowed 4 □ Divorced	If Yes, Give A Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: wh	ite
21215-0036	72 hours after death with the Maryland natural; or items 23e or 28e-f show dical Examinar must be notified at	Completed	15. Decedent's E	ducation ade completed)	16a. Dece	dent's Usual Occupa	ation during most of worki	ing	16b. Kind of Business/l	ndustry
2	ithin Ban 1	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	)			
7	ygier ygier her th		17. Father's Name (First, Middle, Last	2		nomemaker	18. Mother's Name	/First Middle A	own hor	ne
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If the 21 is merked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminar must be notified at	Be		npbell			Kather		nes McNe	din
<u>=</u>	hould d Mer nark natic	ဥ	19a. Informant's Name/Relationship (	-	19h Maili	ng Address (Street a			City or Town, State, Zi	
S	d 2 sl th an th an traum		Keith C. Frederic			Box 961,			•	
ē,	1 an Heal tem 2	1	20a. Method of Disposition		20b. Place of Dispo	osition (Name of			20c. Location - City or T	own, State
ē	ages ant of it: If ii		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Removal from State		matory or other place Ltan Crema	1	-2004 A	lexandria,	VA
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra		21. Signature of Funeral Service Lice		·	2. Name and Addres				20676
B	Depa Impo		1 Wolson B	5mm	Ra	ausch Fune	eral Home	, P.A.,	Port Repub	The second second
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SEPS						Onset and Death
4	/Medical		resulting in death)	a	consequence of):					
	Examiner		Sequentially list conditions	b. COPD	exace	rbation				1 monts
	р <u>#</u>	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a	consequence of):					
	ecute and -trans	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):					<u></u>
760,	certificate be executed iding physician and ise as the burial-transit	cal E		500 10 (01 23 2	55/155455/155 517:					
687	cate physi the			_ d						
×6	w requires that the death certificate been signed by the attending phys should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome of					23d. Date of deliv	rery
Bo	atter after I for u	ciar	in the past 12 months?	1□Live birth 2 4□Pregnant at ti		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>			Month	Day Year
P.O.	that the d ed by the detached	nysi	9 Unknown	9 Unknown		- Colonia				
	s that ned to e deta	y P	Part II. Other significant conditions		not resulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	requires een sign rould be	edt	HTN, CAD,	CHE				1 □ Ye	s 2□No 3□Pro	bably 4 ⊠Onknown
000	aw re	plet						24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Ä	The lav	E						perform	ned? death?	
ita	i <b>clan:</b> Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death			
of Vital Records,	Physiclan: this certific ral director,	5	1 ☐ Yes 2 ☑ MG	Hospital: 1 Impatient	and the second second				nce 6 Other (Speci	fy)
	ft er	on:	27. Manner of Death  1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day)	/ear) 28b. Time o	Work	(?	28d. Describe ho	w injury occurred	
Sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		. At home form at		fes 2 □No	28f Location (Str	eet and Number or Rur	al Pouto Number
Division	or At or At or At Direct in by	Certification:	4 Homicide determined	building, etc.	r - At home, farm, st (Specify)	reet, ractory, office		City or Town,		ar noute warnes,
_	pital	2	29a. Certifier 1 Certifying Pl	nysician: To the best of	my knowledge, deat	h occurred at the tim	e, date and place,	and due to the ca	use(s) and manner as	stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical		miner: On the basis of e and manner state	xamination and/or in					
	ro the rithin ro the	Me	29b. Signature and title of certifier	<del>=</del> -		29c. License	number	29	d. Date signed (Month,	Day, Year)
			)			D3	6969		411104	
			30. Name and address of person who	completed cause of dea	th (Item 23a) (Type,	Print)	,		h. h. O / -	
_	10		SCARIA MAT	HEW MD,	11910 14.	a TRUEM	AN RD	LVSBY	WD 5002	)
	Sta		31. Date filed (Month, Day, Year) APR 0 5 20	3 Registrar	s Signature					
	Registi	ar	AFR U D ZU	U4 STERRA	S. AD	W.				

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Thelma Lorayne Feaster 2004 3:20 pm March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Homewood at Crumland Farms Frederick Frederick 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Birthplace (Stete or Foreign Country) Months Days 1 □ M 2 🖾 F Hours 220-03-2933 84 Yrs. Director Frederick, MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Brunswick ty∑ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 620 Brunswick Street 21716 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify. White ģ 3 ☑ Widowed 4 ☐ Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife Important: if item 27 is marked other any injury or other treumatic event, II once. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Walter A. Ridenbaugh Mabel L. Tederick ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 912 East "F" Street, Brunswick, MD 21716 Sylvia L. Myers, Daughter 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park Heights Cemetery 3/25/04 Brunswick, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Swner Owner John T. Williams Funeral Home Williams, Barbara 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical liovascular disease Due to (or as a consequence of) Be Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as e consequence of): Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 28c. Injury at Work? 28d. Describe how injury occurred

use as the bunal-transi To the Hospital or Attending Physician: Within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Certification:

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page 2 should be detached

After this certificate has

Division of Vital

grown to phyloleian

if than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Hygiene.

Pages 1 and 2 should be nent of Heelth and Mental

Examiner

The law requires that the death certificate be executed

Theima L.

3/24/04

1 ∐ Yes	2
Manner o	
1 Natu	rel
2 Accid	dent

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Yeer) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of injury

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a.	Certifie
	(Check
	one)

icai Medi

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated.

29b. Signature and title of certifie

30. Name and address of person who

29c. License number

31. Date filed (Month, Day, Year)

OOK 32. Registrar's Signature

ause of death (Item 23a) (Type, Print)

completed



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		•	1 - State Registrar		01410 011	· · a · y · ca · ·		rtificate of				g. No. 2	004	1290	1 6
			1. Decedent's Name	e (First, Middle, La	ast)						Date of Deat Month		Year	3. Time of Deat	th
	Physici: /Medic		Vivi	an Kall	len Fawl	ey						20,	2004	8:40 A	М
	Examin	er	4a. Facility Name (II		ve street and numbe	er)		4b. City, Town, o					unty of Death		
	Funeral		2939 F 5. Social Security No		Sex 7	Age (In yrs.	last birthday)	If Under 1 Year	erson	24 Hrs. 8.1	Date of Birth		ederi 9. Birth	ck place (State or Fore	eian
	Funeral Director		219-12-		1₩ 2□F	96	Yrs.	Months Days	Hours		(Month, Day, Jan •			place (State or Forentry) VA	
	Du .		Usual Residence of 10a, State	Decedent 10b. County		10c Cit	y, Town or Lo	cation						10d. Inside City Lim	nite
	Aanyla F show	ō	MD	Frede	erick	100.01	Jeffe							1x ExYes 2 □	
	28e-	rect	10e. Street and Nun					10f. Zip Code			10	0g. Citizen	of Whal Cou	ntry?	
	th with	Funeral Director	3649 Je	fferson	n Pike			2	1755				USA		
	tems	uner	11. Marital Status		12. Was Decede Armed Force	s?	.S. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Original An, Mexican	gin? (Specify n, Puerto Rica	Yes or No- an, etc.)	14.	Race - Ameri Black, White,	can Indian, etc.	
36	rs afte	by F	1 ☐ Never Marrie 3 ☐ Widowed	ed 2 Married 4 Divorced	1 ☐ Yes 2 [ If Yes, Give Year or Date			1□Yes 2√2No	Specify:			Sp	ecity: Wh	ite	
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. ed other than "natural", or Items 23e or 28e-f show event, the Modical Exerting required to indiffied at	ted	/C	15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	pation	t of working	1	16b. Kind	of Business/In	dustry	
21	within 7 iene. than "r	Completed	Elementary/Secon	ify only highest gr ndary (0-12)	College (1-4c	or 5+)	1	kind of work done DO NOT use retire	•	t or working					
121	filed w Hygier other th		17. Father's Name (	(First Middle Las	t)		road	d forema		er's Name (Fil	ret Middle M		te ro	ads	
and	should be filed withir de Mental Hygiene. marked other than matic event, the Mental than the matic event.	To Be		L. Faw						vie C					
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	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Ethel T	oms (Da	ughter)	,		Pete V							69
Baltimore,	it of He if Iter or oth		20a. Method of Disp 1 ₩ Burial 2	Cremation 31	Removal from Sta			sition (Name of natory or other pla		Date			on - City or T		
Ē	Pa ant ury		° 4 ☐ Donation 21. Sign to re of Fu	5 Other (Speci	in	Uni		emetery						lle, VA	_
Ba	permit. Departr Importa		1/4	201	TILDY	The	- 31	haid Ag	in St	mpson	Fune	eral	Home	21769	
			23a Part 1. Enter t	ne disease, or con	n plications that caus	ed the death							,_MD_	Approximate Interval Between	
	Physician	2	Immediate Cause (	Final	2	,	onie							Onset and Death	
	/Medical Examiner		resulting in death)	(	Due to (or	as a conseq	uence of):	,						1	
	Lxammer	7	Sequentially list con	nditions,	b. Due to (or a	as a conseq	uence of):								_
	uted J nnsit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde that initiated events	rlying 4	200 10 (0.0		30.100 0.7.								
oʻ	e be executed /sician and e burial-transit		resulting in death) L	ast	Due to (or	as a conseq	uence of):								
3760,	w . w	Ical		•	d										
89 x	The law requires that the death certification at the bas been signed by the attending phy bage 2 should be detached for use as the	Physiclan/Med	IF FEMALE:		23c. If yes, outcom	ne of oregna	1001								-
Вох	attend I for us	clan	in the past 12	months?	1 Live birth	2 Feta	Ideath 3	Ectopic pregnance Other (specify)	у			230.	Month	Day Year	
P.O.	that the de led by the a detached to	hysi	1 □ Yes 2 □ 9 □ Unknown		9□ Unknown	1									
	w requires that been signed b should be deta	by P	Part II. Other signif	icant conditions	contributing to death	n but not res	ulting in the u	nderlying cause giv	ven in Part I.		23e. Did tob	.0		ne cause of death?	
ord	equire sen si lould l	ted									1 Te	s 2 2N	o 3∏Prot	oably 4 Unkno	wn
Vital Records,	e law has b	Completed									24a. Was an autopsy perform	,	b. Were auto prior to co death?	psy findings availai mpletion of cause o	bie of
a			05 144	rad to madical	T						1□ Yes 2	No	1 🗆 Yes	2 No	
Ž	Physiclan: The this certificate har al director, page	To Be	25. Was case referrence examiner?	/	Hospital: 1 ☐ Inpa	atient 2 🗆	ER/Outpatier	t 3 DOA Ott		of Death (Charsing Home			Other (Specif	v)	
Division of	ng Phys ter this neral di		27. Manner of Death		28a. Date of Ir		28b. Time of Injury	28c. Injur	ry at	and the second	Describe how			,,	
Sior	eath. or; Af the fur	catlo	2 Accident	investigation	on be			M 1 🗆	Yes 2□	_					
Ν	or Ati	Certification;	4 Homicide	determined	28e. Place of	Injury · At ho etc. (Specify		eel, factory, office			Location (Str. City or Town,		ımber or Rura	I Route Number,	
	ours a		29a. Certifier	1 Certifying P	hysician: To the be	sl of my kno	wledge, deatl	occurred at the til	me, date and	d place, and	due to the car	use(s) and	manner as s	ated.	1/1
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After thi completely filled in by the funeral	Medical	(Check only one)	2 Medical Exa	miner: On the basis and manner	of examina	tion and/or in	vestigation, in my o	opinion, deat	th occurred a	t the time, da	te and place	ce, and due to	the cause(s)	
4	To t To t	Σ	29b. Signature and	title of certifier	00	MN		29c. Licens	se number	7			gned (Month,	•	
			*	WW	your	• •	20-1-7	U U	166	15		FIRE	007	2, 2004	
	1		30. Name and addre	1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	completed cause of	death (Item			U5 W10	ch d	MU	21	716		
	Sta		31. Date filed (Mont		-	strar's Signa	-	Ander							
	Registr	rar		- THE 2 !	S COUY	Margaret !	St.	4						¥40	

			State of Maryland / Departme		·
			_ FOI	ate of Death	Reg. No. 2004 12992
			Decedent's Name (First, Middle, Last)	2. Date Mont	e of Death 3. Time of Death
4	Physicia /Medic		John Arthur Frederick, Sr.	March	
£.	Examin			ty, Town, or Location of Death	4c. County of Death
			Union Hospital of Cecil County Elki  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Union		e of Birth  9. Birthplace (State or Foreign
	Funeral Director		219 07 3504 1X M 2 F 82 Yrs. Month	ns Days Hours Min. (Mon	e of Birth 9. Birthplace (State or Foreign Country)  .y 28,1921 Maryland
	ס		Usual Residence of Decedent		
	arylar show	Ä	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 🏻 No
	the M	ecto	Maryland   Cecil   North East   10e. Street and Number   10f.	Zip Code	10g. Citizen of What Country?
	3a or	Funeral Director		1901	United States
	death	nera		cedent of Hispanic Origin? (Specify Yes pecify Cuban, Mexican, Puerto Rican, et	
9	or Ite	y Fu	1 ☐ Never Married 2 ② Married 1 1 ☐ Yes 2 ☐ No 1 ☐ Yes Give 1 ☐ Yes	2 No Specify:	Specify: White
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or flems 23e or 28e-f show fa Mardical Examinar must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's U	sual Occupation	16b. Kind of Business/Industry
7	n nai	Completed	(Specify only highest grade completed) (Give kind of life, DO NO)	work done during most of working	Tob. Nine of Besiness measury
212	d with giene er the	Com	Elementary/Secondary (0·12) College (1·4or 5+) 8 Mechanic		Aberdeen Proving Groun
p	be filed stal Hygis of other event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, N	V-1-2-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-
<u>Ş</u>	should Ind Mening Marke	L <sub>O</sub>	John Frederick	Maude Hamilt	Number, City or Town, State, Zip Code)
Maryland	d 2 sh th and 17 Is n treun		, , , ,		ad, North East, Maryland2190
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or Items 23a or 28a-1 show entry or other treumatic event, Ite Medical Examinating Items at an ance.		20a. Method of Disposition 20b. Place of Disposition (A	Vame of Date	20c. Location - City or Town, State
Ê	Pages nent of int: If it		1 IX Burial 21 Cremation 31 Internoval from State	Methodist March 30,	,2004 North East, Maryland
Baltimore,	permit. Departmitimporta eny inju		21. Signature of Funeral Service Licenses 22. Name	and Address of Facility Crouch	Funeral Home
_	80799			South Main Street,	North East, Maryland 21901
			23a. Part1, Enter the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line.	lode of dying, such as cardiac or respirat	atory arrest, Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Acute Myocard	dial Intarct	FION
	Examiner		Due to (or as a consequence of the coscleration	Cardiovascula	C Disease 4 years
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Car 6101436014	0.000
KR	ecuted ind transi	Examiner	that initiated events C.		
760,	be executed sician and burial-transif	aiEy	Due to (or as a consequence of):		
387	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit		d		
Box 68	ncertii nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
	death	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other	c pregnancy (specify)	Month Day Year
P.O.	at the	Physician/Medi	9 Li Unknown	a server arran in Don't I	e. Did tobacco use contribute to the cause of death?
	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying the Part II. Other significant conditions contributing to death but not resulting in the underlying the Part II. Other significant conditions contributing to death but not resulting in the underlying the Part II. Other significant conditions contributing to death but not resulting in the underlying the Part II. Other significant conditions contributing to death but not resulting in the underlying the Part II. Other significant conditions contributing to death but not resulting in the underlying the Part II. Other significant conditions contributing to death but not resulting in the underlying the Part II. Other significant conditions contributing to death but not resulting in the underlying the Part II. Other significant conditions contributing the part of the Part II. Other significant conditions contributing the Part II. Other significa	g cause given in Part I. 236.	1 ☐ Yes 2 ☐ No 3 ⚠ Probably 4 ☐ Unknown
Ö	v requ been shouk	etec	Diahetes Mellitus	24a	a. Was an 24b. Were autopsy findings available
Be	he lav e has age 2	Completed	Digoetes from 13		autopsy prior to completion of cause of death?
ta	en: T tificat tor, pa	0	25. Was case referred to medical	26. Place of Death (Check	
>	hysici nis ce I direc	ToB	examiner? 1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Home 5	☐ Residence 6 ☐ Other (Specify)
0 0	ing Pl		27. Manner of Death  1 ☑Natural 5 ☐ Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	Work?	escribe how injury occurred
Division of Vital Records,	Attending Physicien: ir death. ector: After this certifics by the funeral director. I	icat	2 Accident investigation M 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact	1 ☐ Yes 2 ☐ No	cation (Street and Number or Rural Route Number,
Σ	of or A after Direct	Certification:	4 Homicide determined building, etc. (Specify)	City	y or Tòwn, State)
	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurr (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation		
	To the H within 24 To the Fi complete	ledical	one) and manner stated.		
_	with To Con	Σ	29b. Signature and title officertifier	29c. License number	29d. Date signed (Month, Day, Year)  MARCH 30, 2004
	C1.1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	738861	March 30, 2004
	Ex,		DAVID Hexter 106 Bow S	street Elkto.	N. MO 21921
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	7	
	Registi	ar	APR 1 2004 15 15 15 15 15 15 15 15 15 15 15 15 15	/	

Physician / Medical Examiner    Discooled its Name (First, Middle, Last)   2. Date of Death Month April 4, 2004   2244				For State						of Health		ental Hy		2001	1 129
## Commerce   County of Dearn   Acc County o		Physic	ian	Decedent's Nar	me (First, Middle, La	ist)		29/U4~Jr	imouto	or Beati	4	Month	aath Day	Year	3. Time of Death
Marrier   Talbot									4h City To	um or Location		prii			
So Seed absent Number 6 Seed absent Number 6 Seed and See		Exami	ner								I OI DOAIII				
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The State of Decoder   The State   The S									Months D	ays Hours	Min.	(Month, Da	19, Year)		
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Sandtown Cemetery   04/10/2004 Hillsboro, Maryland   20   20   20   20   20   20   20   2	ē,	of Heilitam		20a. Method of Di	sposition	•		Place of Dispo	sition (Name	of	Da	te			
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes   2   No 3   Probably 4   Otherwise of death?	9	ding p	Me	IF FEMALE:		220 16 100 01400									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes   2   No 3   Probably 4   Otherwise of death?	Bo	attenc for us	lan			1☐Live birt	th 2 ☐ Fet	tal death 3							
25. Was case referred to medical examiner?	Ö	the shed	ysic	1 ☐ Yes 2	2 PNo			death 5L	Other (specif	y)					,
25. Was case referred to medical examiner?	۵.	that the	P.			contributing to dea	th but not re	sulting in the u	nderlying caus	e given in Part	I.	23e. Did t	obacco use c	ontribute to t	he cause of death?
25. Was case referred to medical examiner?	ds,	sign d be	d b	ADULT	PONSOT	DiALIT	72/		,	3					
25. Was case referred to medical examiner?	Ö	been shoul	ete			11.1.7810	·								
25. Was case referred to medical examiner?	ec	has has	шb									autor	an 24	b. Were auto prior to co	psy findings availal impletion of cause of
26. Place of Death Check onl. one  27. Manner of Death 1   Yes   Y	<u>a</u>												2 No	1 Yes	2₽No
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ludwig Eglseder III. M.D. 403 (Cymyrood Dr. Factor Maryland 2160)	<b>1</b>	iciar certif recto		examiner?		Hospital:									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ludwig Eglseder III. M.D. 403 (Cymyrood Dr. Factor Maryland 2160)	32	Physical dis				1 1 mg									(y)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ludwig Eglseder III. M.D. 403 (Cymyrood Dr. Factor Maryland 2160)	3 5	ding After fune	Hon	1 Natural	5 Pending		Day Year)			Work?		u. Describer	low injury occ	uned	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ludwig Eglseder III. M.D. 403 (Cymyrood Dr. Factor Maryland 2160)		24 h 24 h e Fur	dic		2 Medical Exam	niner: On the bas	is of examin	ation and/or in	estigation, in	my opinion, dea	ath occurred	at the time,	date and place	e, and due to	the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ludwig Eglseder III. M.D. 403 (Cymyrood Dr. Factor Maryland 2160)		To th within Го th	<b>≅</b>	29b. Signature an	d title of certifier	01			29c. Li	cense number			29d. Date sig	ned (Month,	Day, Year)
30. Name and address bit person who completed cause of death (Item 23a) (Type, Print)  Ludwig Eglseder III. M.D. 403 Cymyrood Dr. Factor Maryland 21601				1/	1 11	16/1	2 m	2	D	3/4/	1		4/1	1/00	,
Ludwig Eglseder JII. M.D. 403 Cynwood Dr. Faster Maryland 21601	_			30. Name and add	drass of person who	completed cause	of death (Ite	m 23a) (Type.	Print)	- 101	9		119	109	
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Physician (Medical Examiner)  23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increas blower shock, or heart failure. List only one cause on each line.  23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate Introduction and the property of the death of the cause of d		id be filed v ental Hygie ked other t ic event, ID	o Be Co	17. Father's Name				1	поше	Mexic	18. Mother's	Name (	First, Middle, y Kin	Maide			
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Physician Medical Examiner  Ph	Balti	parmit. Departr Importa any inji		21. Signature of Fu	uneral Service Licens	Islem		2	2. Name	and Addre	n St.,	Fran Fed	ptom F eralsb	une ourg	ral Hom , MD 21	e, P 632	.A.
Second Second	60,	/Medical Examiner cian and pnuial-transit		shock, or hea Immediate Cause disease or condition resulting in death)  Sequentially list confirm to include. Enter Under Cause (Disease or that initiated events	int failure. List only of (Final on on on on on on on on on on on on on	a. Due to (or as a Due to (or a) Due	a conseq	uence of):	ter the m	$\cap$		ralac or r	espiratory at	rrest,		Inten	al Between
1   Yes   2   No   3   Probably   4   2011	O. Box 687	he death certificate / the attending phys ched for use as the	ysician/Medic	23b. Was deceded in the past 12 1 Yes 2	it pregnant months?	23c. If yes, outcome of 1 ☐ Live birth	2 Feta	I death 3			у					-	Year
29a. Certifier 29a. Certifier 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ds, P.	luires that t n signed by ild be deta	þ	Part II. Other signi	ficant conditions co	ntnbuting to death bu	ut not res	ulting in the I	underlying	g cause giv	ven in Part I.						se of death?
29a. Certifier  Check only one)  29a. Certifier  Check only one)  29a. Certifier  Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	Recol	The law recate has bee bage 2 shot	omplete										autop	osy irmed?	death?		
29a. Certifier   1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)   2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)	/ita	cien: ertifica ector,	Be	25. Was case references	<u> </u>				-	0.1		Death (	Check only o	ne)			
29a. Certifier   1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)   2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)	on of \	iding Physi th. : After this o funeral dire		27. Manner of Dea	th 5 Pending	1 Lampatie		28b. Time	of	28c. Injur	ry at rk?	28	· · · · · · · · · · · · · · · · · · ·			ecify)	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (Check only one)  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	Divisi	lel or Atter s after dea al Diractor ed in by the	Certifica	3 🗌 Suicide	6 Could not be	28e. Place of fniu building, etc	ury - At he	ome, farm, si	treet, fact	ory, office		28				lural Rout	e Number,
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  10 A Year Month of the Month o		ne Hospit n 24 hour he Funera oletely fille		(Check only		iner: On the basis of	examina										ause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Karen Moffett M. D. Log Doffin Lane Denton Min 21629		To ti withi To ti comp	Z	29b. Signature and	d title of certifier	1	DU	DRK				,39					(ear)
State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	_			Kare	n Moffe	it, M.D.	,60	9 Da		La	ne, D	ento	on, M	0	21629		

Registrar DHMH 17 Rev 1/2001 2004

			1 - For State Registrar		ryland / Depa Cea		Health and N	lental Hyg	-	
	Physici /Medi	cal		GEORGE	GABRIEL			2. Date of Dea Month MARCH 2	27, 2004 <sup>Y</sup>	3. Time of Death 10:00 A
	Examir Funeral	ner	4a. Facility Name (If not institution, give 12212-BB GILLESP 5. Social Security Number 6. Se	IE CIRCLE	(In yrs. last birthday)		LDORF If Under 24 Hrs.	8. Date of Birth	4c. County of CHARLE	
ו	Director		193-40-1453  Usual Residence of Decedent  10a. State 10b, County	X M 2□F   5	53 Yrs.	Months Days	Hours Min.	NOV 7,	1950 F	PENNSYLVANIA
the Maryla	28a-f show	Director	MARYLAND CHARLES  10e. Street and Number		10c. City, Town or La	ALDORF	la tarda		log. Citizen of Wha	10d. Inside City Limi 1 ☐ Yes 2 💢 N
th with	23a or		12212-BB GILLESPI	E CIRCLE		7 or. 2 p 0000	20602		UNITED S	
72 hours after death with the Maryland	al', or items 23a or 28a-1 show Exactract by notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Drorced	12. Was Decedent Ev Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:	er in U.S. 13. \	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. WHITE
72 ha		eted	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	lent's Usual Occup kind of work done	during most of work	ing	16b. Kind of Busin	ness/Industry
within	lene. r than "natul Ine Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		SHARPEN	-/		CVM CHV	RPENING
99	od other	To Be C	17. Father's Name (First, Middle, Last) MORRIS GABRIEL	<u>-</u>	JAM	JIAN LI	18. Mother's Name	e (First, Middle, I		RELITING
2 sho	and is m		19a. Informant's Name/Relationship (T)				and Number or Run			
1 and	item 27 other tra		ZANITA ZACKS – ATTO 20a. Method of Disposition		20b. Place of Dispo-	sition (Name of		Tato	PA 1650 20c. Location - Cit	
Pag	rtant: If		1 ☐ Burial 2 X Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State	HUNTT CRE	MATORY	MARC 200	H 30,		MARYLAND
permit.	Departr Importa any inju once.		21. Signature of Funeral Service Licens	M00053		Name and Addre	SS OF Facility RAL HOME,	P O ROX	' 156 WΔ	20604
/N	ysician Medical aminer		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the ne cause on each line.  a. Due to (or as a control of the cause of the	e death. Do not ente	or the mode of dying		or respiratory arre		Approximate Interval Between Onset and Death
le be executed	sicien and burial-transit	dical Examiner	Sequential y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c		<i>(-)</i>				ZYRS
the death certifical	igned by the attending phy be detached for use as the	by Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of a 1  Live birth 2	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
requires that the	been signed be should be deta		Part II. Other significant conditions con	ntributing to death but n	not resulting in the un	derlying cause giv	en in Part I.			e to the cause of death?  Probably 4 Unknow
The law	cate has be page 2 sh	Completed						24a. Was ar autopsy perform 1 Yes 2	prior deat	a autopsy findings availab to completion of cause of 1? Yes 2 \( \subseteq \text{No} \)
Physician:	certif	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	2 [ ED/O	3C DOA Othe	26. Place of Death			
Attending Phy		H +	27. Manne Death 1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of Injury	28c. Injun Work	4   Nursing Hor		nce 6 Other (5 w injury occurred	Specify)
5	ral Directo	Certific	3 Suicide 6 Could not be determined	building, etc. (\$				City or Town,	State)	r Rural Route Number,
	the Fune	edical	29a. Certifier 1. Certifying Physical Check only 2 Medical Examinations)	sician: To the best of mer: On the basis of exa and manner stated	amination and/or inve	occurred at the timestigation, in my op	ie, date and place, a pinion, death occurre	and due to the called at the time, da	use(s) and manner te and place, and o	r as stated, due to the cause(s)
To the	Tot	-	29b. Signature and title of certifier	ged las		29c. License	number 345		d. Date signed (Me	
2	Stat		30. Name and address of person who concern the GEORGE LEON, MD, 3 31. Date filed (Month, Max, Year) 1	ted cause of death 3261 OLD WA	SHINGTON F		OORF, MARY			

State of Maryland / Department of Health and Mental Hygiene

_						Certif	icate of	Death		Reg. No. 🥎	100	10000
	Physic	ian	Decedent's Name (First, Middle, La	st)					2. Date of De	ath	0 0 4 3	Time of Death
m only	/Medi		Estridge Lee G						April	6,200	4 1941 5	:35 pm
	Exami	ner	4a Fecility Neme (If not institution, giv					4b. City, Town, or I			ty of Death	
			Fort Washingto					Fort Wa		l l	ince G	eorge
150	Funeral		Social Security Number     6. S	ex 7. Age □XM 2□ F	(In yrs. last bir	M/	Under 1 Year onths Days		(Month, Da	h v. Year)	9. Birthplace	(State or Foreign
	Director		175-18-5901 Usual Residence of Decedent	9	2	Yrs.			Augus	t 23,1	911 Vi	rginia
	Pw #		10a. State 10b. County		10c. City, Town	or Location	on .				104	Inside City Limits
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	th the Marylen or 28a-f show	Je.	10e. Street and Number	.05	11101		Of. Zip Code			10- 011		
	3 or		3219 Jenkins La	no			206	4.0		-	What Country?	
	72 hours eftar death with the Marylend natural', or flems 23a or 28a-f show dical Examinet must be notitled at	Funeral Director	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13 Was			noity Voc or No	U.S	ce - American Ir	ndia a
0	far far	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		If Yes	s, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Bi	ack, White, etc.	idian,
07	urs e	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:		101	∕es 2DNNo	Specify:		Specify: Wh		
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21	within 7 ene. than "r	ed l	(Specify only highest gra	de completed) College (1-4or 5+)		(Give kind life. DO N	of work done IOT use retire	during most of worl d)	ing			,
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nd	al Hygie d other i	Be	17. Father's Neme (First, Middle, Last)					18. Mother's Nam	e (First, Middle,	Maiden Surna	me)	
Maryland	Ment Ment Price	2	Bertie T. Grigs	sby				Virgi	e Hei	nderso	n	
lar	2 sho end is m		19a. Informant's Neme/Relationship (7	ype, Print)	19b.	Mailing Ad	Idress (Street	and Number or Rui	el Route Numbe	r, City or Town	, State, Zip Cod	(e)
≥,	end salth		Frances Grigsb	y wife				s Lane,			, Md.	20640
Baltimore,	permit. Pagas 1 and 2 should be filed Depertment of Health and Mental Hyg Important: If item 27 is marked other injury or other traumatic event, anty injury or other traumatic event,	- [	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of cemeters	Disposition	(Name of	al GArd	Date	20c. Location	- City or Town,	State
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1	Physician		snock, of hear failure. List only o	one cause on eech line.				<b>5</b> ,	- · · · · · · · · · · · · · · · · · · ·	001,	Inter	roximate val Between et and Death
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		1	For State Registrar	State of Maryla	and / Depa		Health and		iene 99. No. 200	4 12997
gar.	Physici /Medic	al	Decedent's Name (First, Middle, Las     Anthony     Anthony  4a. Fecility Name (If not institution, give	(	Gray,I		or Location of De	2. Date of Death Month April	Day Yea 11, 200	4 7:55 P M
	Examin Funeral Director		Millennium Hea 5. Social Security Number 6. Sr 220-68-5830	1th & Rehat	o. Ctr rs. last birthday) +8 Yrs.		gewater	rs. 8. Date of Birth	Anne Ar	
	the Maryland	rector	Usual Residence of Decedent           10a. State         10b. County           Yaryland         Calv           10e. Street and Number	ert	City, Town or Lo	Owin	gs	10	ng. Citizen of What (	10d. Inside City Limits 1 ☐ Yes ②☐ No Country?
Baltimore, Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itams 23a or 28a-f show ta Medical Exeminer must be notified at	y Funeral Director	8880 Grovers  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1			(Specify Yes or No- erto Rican, etc.)	USA  14. Race - An Black, Wi	
	within 72 hours iene. 'then "natural"	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed (Specify only highest gra  Elementary/Secondary (0-12)  1 2		(Give	dent's Usual Occu kind of work done DO NOT use retire Truck D	during most of wed)	rorking	16b. Kind of Busines	
yland 2	ould be filed Mental Hygi barked other hatic evant, I	To Be C	17. Father's Name (First, Middle, Last) 0 scar Jam				Marth		elle :	Mullen
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o	ding Physi T. After this c funeral dire	ilon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of	f 28c. Inju	her: 4 Shursing	eath (Check only one Home 5 Reside 28d. Describe hor	nce 6 Other (Sp	pecify)
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	To the Hospitel or Attand within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examone)  20h Signature and title of partifier	ysician: To the best of my kiner: On the basis of examinand manner stated.	ination and/or in	vestigation, in my	opinion, death oc	curred at the time, da	te and place, and du	ue to the cause(s)
7	8	100	30. Name and address of person who	completed cause of death (II	tem 23a) (Type,	Print) GYA	7063 AN -0	SURA	NA シカフで	
	Sta Regista			3 2004 Sign	gnature	Spark	0	// (J)		

			_ For	State of Maryland					-							
			1 - State Registrar		Ce	rtificate of Dea	ith	Reg.	No. 2001	12998						
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-	Examir	ner	4e. Fecility Name (If not institution, give			4b. City, Town, or Locat			4c. County of Dear							
			5. Social Security Number 6. Se		and the laster also a co	FUNT WASIT			PRINCEG							
	Funeral Director			7. Age (In yrs. la ☐ M 2](1) F 44	Yrs.	Months Days Hou	urs Min. 8. Date May	of Birth th, Day, Yes 30,1	9. Bin 959 Mar	thplace (State or Foreign puntay) y Land						
	Maryland f show	tor	100 State 10h Causti	ince	Town or Lo	washington	n	-		10d. Inside City Limits 1 ☐ Yes 2 ☐ No						
	h with the 23a or 28a al be noti	Funeral Directo	10e. Street and Number 7304 Craffore			10f. Zip Code 20744		1 -	Citizen of What Co	ountry?						
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	Þ	11. Marital Status  X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hispanic f Yes, specify Cuban, Mex 1 ☐ Yes 2 ☒ No Spec	cican, Puerto Rican, e	or No-	14. Race - Ame Black, White Specify: B							
5-0	72 hc natur	eted	15. Decedent's Ed	ucation de completed)	16a. Deced	tent's Usual Occupation	most of working	16b.	Kind of Business/	Industry						
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nd	be file ital Hy id other	Be (	17. Father's Name (First, Middle, Last)			ļ.	other's Name (First, A	Aiddle, Maid	en Sumame)							
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, Maryland	1 and 2 sho Health and I em 27 is ma		19a. Informant's Name/Relationship (T Curtis Word/Sor	ı	7304	g Address (Street and Nu.	P1. Ft.	Vu <i>mber, Cit</i> y Wash:	or Town, State, 2 ington,	Tip Code) MD 20744						
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 3 ☐ Other (Specify,	Removal from State	netery, cren	sition (Name of natory or other place) ematory	Date 4/9/2004		Location - City or exandri							
Balt	permit. Pag Department Important: I any injury o		21. Signature of Fungral Service Licens  Place 4.	Lewelf	1 4	Name and Address of Fa 51 Dares F	Beach Rd.	Fun Prin	eral Ho	me .,MD20678						
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. ne cause on each line. a.  Due to (or as a conseque	Do not enter	rhifthmic	as cardiac or respira	tory arrest,		Approximate Interval Between Onset and Death						
	Examiner put	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events of cause (Disease)	b	nce of):	lenal Diseu	ase			years						
68760,	cate be executed ohysicien and the burial-transit	a	a l													
P.O. Box 6	or Attending Physician: The law requires that the death certificate be executed that death. Differ death. Differ death. Differ this certificate has been signed by the attending physicien and biffer tors: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit.	ysician/Me	ıysician/Me	ysician/Med	ysician/Med	ıysician/Mec	Physician/Medic	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnanc 1 ∐Live birth 2 ∏ Fetal d 4 ∏ Pregnant at time of dea 9 ∏ Unknown	eath 3 🗆	Ectopic pregnancy Other (specify)		_	23d. Date of deline	very Day Year
	uires that signed b	by	Part II. Other significant conditions con	ntributing to death but not resulti	ing in the un	derlying cause given in Pa	art I. 23e.	Did tobacco		the cause of death?						
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a F	nysician: The la nis certificate ha I director, page 2						10	performed?	death?							
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of	Phys r this sraidi	: To	VI Yes 2 No  27. Manner of Death	I Inpatient 2 Kg EF	VOutpatient 8b. Time of		Nursing Home 5			fy)						
ion	nding I tth. :: After e funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No			njury occurred									
Division	tal or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom- building, etc. (Specify)	e, farm, stre	et, factory, office	28f. Local City of	ion (Street a or Town, Stat	and Number or Rur te)	al Route Number,						
	Hospit 4 hour Funera ely fille	Medical C	29a. Certifier 1 ☐ Certifying Phy: (Check only one) 2 ☐ Medical Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time, date estigation, in my opinion, o	and place, and due to death occurred at the	the cause(	s) and manner as : nd place, and due !	stated. to the cause(s)						
7	To the within 2 To the complet	Me	29b. Signature and title of certifier	Omara, MIS		29c. License numbe		29d. D	ate signed (Month,							
	3		30. Name and address of person who co	empleted cause of death (Item 2	3a) (Type, F	Print)		NMI	/ /	· ·						
	Sta Registr	te ar	31. Date filed (Month, Day PR 0	32. Register's Signatur	° K	South 8			- , ,							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** 18. March 2004 HARRY TYDINGS GIBSON 9:00 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 0ct.5, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ∰M 2 ☐ F Months Maryland 219-16-6098 81 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow other traumatic event, the Mudical Examinar must be notified at 1 Yes 2 □ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 750 Carroll Parkway #5A 21701 U.S.A. or Itams 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 PYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖁 No If Yes, Give Year or Dates: WWII Specify: ģ Specify: 3 XWidowed 4 ☐ Divorced White "natural" Completed t6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Engineer Hospital permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othing any jointy or other traumatic event RRB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Myers Gibson Mary Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Gibson (Son) 11318 Creagerstown Road, Woodsboro, Maryland 21798 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 3/19/04 Smithsburg, Maryland 21. Signature of Foneral Service L ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 TAINE 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it my leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Deetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 X No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performe 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tyes 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Seath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation M the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) I in by 1 Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) an inpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who Robert L. Kaufman MD 300 West 9th Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

			Otato	or warylar		rtment of F rificate of			0.0	04 1300	
Physi /Med		1. Decedent's Name (First, Mi						2. Date of De Month March	ath Day	Year 3. Time of Death	
Exam		4a. Facility Name (If not institu		umber)			4b. City, Town, or L				
		Goodwill Menne	onite Home				Grantsvi	ille	Garr	cett	
Funera Directo		5. Social Security Number 190–12–4338	6. Sex 1  M 2  F	7. Age ( <i>In yr</i> s. 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Dec 21	th y, Year) , 1922	9. Birthplace (State or Forei Country) Pennsylvania	
pu 🛦		Usual Residence of Decedent  10a. State 10b. Cour	nhy	10c Cit	y, Town or Loca	ation				104 (14-0) 11-1	
shor	5		•							10d. Inside City Limit	
28a-	Director	MD Gari				naconing			10- Citizen of M		
with o	ā	8276 Avilton-	onaconinc	Pond		10f. Zip Code 215	30		10g. Citizen of W	mat Country?	
eath	era	11. Marital Status		cedent Ever in U	.S. 13. W			ecify Yes or No	USA 14 Bace	- American Indian,	
urs after o al', or Iter Examiner	by Funeral	1 □ Never Married 2 ☑ M 3 □ Widowed 4 □ Divord	Armed F arried 1 ☐ Yes If Yes G	orces? 2 <b>∏</b> No iive		Yes, specify Cuba ☐ Yes 2 <mark>∏</mark> No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specify:	k, White, etc.	
s 1 end 2 should be filed within 72 hours after death with the Maryland if Health end Mental Hygiene. If marked other than "netural", or Items 23e or 28e-f show other treumatic event, the Medical Experience must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)				O NOT use retired	rk done during most of working se retired)			16b. Kind of Business/Industry	
Hygie Hygie Ther I		8 th 17. Father's Name (First, Midd	le last)		Homema	aker	18. Mother's Nam		Own Home		
ontal l	Be	Irvin Kemp	0, 2001,				Lulu Du		Waldell Sullaine	5/	
should be and Mental I smarked of umatic eve	2	19a. Informant's Name/Relation	nshin (Tyne Print)		19h Mailing	Address (Street	and Number or Rui		er City or Town 5	State Zin Code)	
d 2 sho th end 7 Is me treum	1	Ellis C. Garl		đ						ing, MD 21539	
permit. Pages 1 end 2 Department of Health en Importent: If item 27 Is any injury or other trea once.		20a. Method of Disposition	, , , , , , , , , , , , , , , , , , , ,			tion (Name of tory or other place		Date		City or Town, State	
ages ant of t: If it		1 X Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		Siale			y, March	13 200		on, MD	
artme prten injur	1 9	21. Signature of Funeral Service		\ 50.							
Dep imp	36 33	Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536									
		23a. Part1. Enter the disease, shock, or heart failure. L.	or complications that ist only one cause on	caused the death each line.	n. Do not enter	the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death	
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Ath		ras a conseque		vascular	. dise	eace	6month	
flicete be executed g physician and as the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>f</b> b	Due to (or	r as a conseque	ence of):					
certificate be ding physici se as the bu	Medical	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
at the death certifi I by the attending stached for use as	Physician/M							1300	-		
the d y the	Jysi	Part II. Other significant condi	_		-	erlying cause give	en in Part I.			ribute to the ceuse of death	
res that signed b	by Pi	Chromi	c Reno	I fa	ilme			1 1 1	′es 2□No 3	3 ☐ Probably 4 ☐ Unknow	
w requi	Completed b							24a. Was a perfor	an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?	
w + m	ě							1 □ Y	es 2 No	1 □ Yes 2 🗡 No	
ilcien: The certificate rector, pag	Be	25. Was case referred to medic	al				26. Place of Death	(Check only or			
Sop	일	examiner? 1 ☐ Yes 2 XÎNo	Hospital: 1 □	Inpatient 2 🗆 I	ER/Outpatient	3□ DOA Othe	er: 4 X Nursing Ho	me 5□Reside	ence 6 □Other	(Specify)	
ig Ph ter th neral	Certification:	ZUNOCIGCIII	tigation	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work M 1 \( \)		28d. Describe how injury occurred			
endir sath. or: Afi he fui	1,2	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							treet and Number n, State)	or Rural Route Number,	
ital or Attending Physicien: rrs efter death. el Director: After this certific led in by the funeral director,	Certif				vledge, death or	ccurred at the tim	e, date and place,	and due to the c	ause(s) and manr	ner as stated.	
Hospital or 24 hours effe Funerel Dir stely filled in	edical	29a. Certifier (Check only one) Certify	ing Physiclen: To the If Exeminer: On the b and man	asis of my know asis of examinati ner stated.	ion and/or inves	tigation, in my op	inion, death occurr	ed at the time, d	ate and place, an	d due to the cause(s)	
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To the Hospital or Attendin within 24 hours effer death. To the Funerel Director: Aft completely filled in by the fur	edical	(Check only 2 Medical one)	ier	asis of examinati	ion and/or inves	tigation, in my op	inion, death occurr	2		d due to the cause(s) (Month, Day, Year)	
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